REDACTED

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation/Petition to Revoke Probation Against:	)	
John C. Chiu, M.D.	)	Case No. D1-2002-141331
Physician's and Surgeon's Certificate No. C 31784	)	
Respondent	)	

DECISION

The attached Proposed Stipulation is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 27, 2012.

IT IS SO ORDERED: March 29, 2012.

MEDICAL BOARD OF CALIFORNIA

Shelton Duruisseau

Shelton Duruisseau, Ph.D., Chair
Panel A

KAMALA D. HARRIS
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation/Petition to Revoke Probation Against: **JOHN C. CHIU, M.D.** **1001 Newbury Road** **Newbury Park, CA 91360** **Physician's and Surgeon's Certificate No. C31784** Respondent.	Case No. D1-2002-141331 OAH No. LA2011080207 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Gloria L. Castro, Supervising Deputy Attorney General.

2. Respondent John C. Chiu, M.D. (Respondent) is represented in this proceeding by attorney Jay Hartz, Esq., whose address is: 1875 Century Park East, Suite 1600 Los Angeles, California 90067.

3. On or about November 4, 1969, the Medical Board of California issued Physician's and Surgeon's Certificate No. C31784 to John C. Chiu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought here and will expire on August 31, 2013, unless renewed.

JURISDICTION

4. Accusation/Petition to Revoke Probation No. D1-2002-141331 was filed before the Medical Board of California (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation/Petition to Revoke Probation and all other statutorily required documents were properly served on Respondent on July 15, 2011. Respondent timely filed his Notice of Defense contesting the Accusation/Petition to Revoke Probation. A copy of Accusation/Petition to Revoke Probation No. D1-2002-141331 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation/Petition to Revoke Probation No. D1-2002-141331. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including his rights to a hearing on the charges and allegations in the Accusation/Petition to Revoke Probation; to be represented by counsel at his own expense; confront and cross-examine the witnesses against him; present evidence and to testify on his own behalf; the issuance of subpoenas to compel the attendance of witnesses and the production of documents; to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent understands and agrees that the charges and allegations Accusation /Petition to Revoke Probation No. D1-2002-141331, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

11. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C31784 issued to Respondent John C. Chiu, M.D. (Respondent) is revoked. However, the revocation is stayed

and Respondent is placed on probation for seven months from July 21, 2011, through February 28, 2012, on the following terms and conditions.

1. SOLO PRACTICE Respondent is prohibited from engaging in the solo practice of medicine.

2. NOTIFICATION Prior to engaging in the practice of medicine, the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

3. SUPERVISION OF PHYSICIAN ASSISTANTS During probation, respondent is prohibited from supervising physician assistants.

4. OBEY ALL LAWS Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

5. QUARTERLY DECLARATIONS Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. PROBATION UNIT COMPLIANCE Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board, or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

7. INTERVIEW WITH THE BOARD, OR ITS DESIGNEE Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee, upon request at various intervals, and either with or without prior notice throughout the term of probation.

8. RESIDING OR PRACTICING OUT-OF-STATE In the event respondent should leave the State of California to reside or to practice, respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California total two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

9. FAILURE TO PRACTICE MEDICINE - CALIFORNIA RESIDENT

In the event respondent resides in the State of California and for any reason respondent

stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

10. COMPLETION OF PROBATION Respondent shall comply with all financial obligations (e.g., restitution and probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

11. VIOLATION OF PROBATION Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. LICENSE SURRENDER Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of

respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, but may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Jay Hartz, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 12/22/11

John C. Chiu, M.D.
Respondent

I have read and fully discussed with Respondent John C. Chiu, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 12/22/11

Jay Hartz, Esq.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: December 22, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California

GLORIA L. CASTRO
Supervising Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Petition to Revoke Probation No. D1-2002-141331

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: **JOHN CHIH CHIU, M.D.** **1001 Newbury Road** **Newbury Park, CA 91360** **Physician's and Surgeon's Certificate No. C31784** Respondent.	Case No. D1-2002-141331 **ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about November 4, 1969, the Medical Board of California issued Physician's and Surgeon's Certificate Number C31784 to JOHN CHIH CHIU, M.D. (Respondent).

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical

Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the division[1], may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the division.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

"(4) Be publicly reprimanded by the division.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the division and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

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[1] Pursuant to Business and Professions Code section 2002, "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

7. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"(f) Approving undergraduate and graduate medical education programs.

"(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

"(h) Issuing licenses and certificates under the board's jurisdiction.

"(i) Administering the board's continuing medical education program.

PROBATION CASE

8. In a prior disciplinary action entitled *In the Matter of the Accusation Against John Chih Chiu, M.D.* before the Medical Board of California, in Case Number 17-2002-141331, the Board issued a decision, effective July 21, 2008, in which Respondent's license to practice medicine was revoked. However, the revocation was stayed and Respondent's license was placed on probation for a period of three (3) years probation with numerous terms and conditions (Probation Order). That decision is now final, is incorporated by reference as if fully set forth here, and is attached here as Exhibit A.

9. Term and Condition 3 of the Probation Order states:

"Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders."

10. Term and Condition 4 of the Probation Order states:

"Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter."

11. Term and Condition 5 of the Probation Order states, in relevant part:

"Respondent shall comply with the Board's probation unit."

12. Term and Condition 6 of the Probation Order states:

"Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation."

13. Term and Condition 9 of the Probation Order states:

"Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final."

ACCUSATION

FIRST CAUSE FOR DISCIPLINE

(Dishonest and Corrupt Acts)

14. Respondent is subject to disciplinary action under section 2234, subdivision (e), in that he has engaged in dishonest and corrupt acts. The circumstances are as follows:

15. Respondent has been on probation since July 2008, and is under an obligation to be honest and truthful in his interactions with the Board and its designees in effectuating all of the terms and conditions of his probation, which includes the requirement to comply with the Board's probation unit and to be available in person for interviews with Board designees. During quarterly interviews with all probationers, Board designees will ask probationers whether there are any civil suit, medical malpractice, or peer review proceedings pending against the probationer. The expectation is that the probationers will be truthful in their answers. The Board's designees rely on the information provided by the probationers in these interactions.

16. In May 2011, the Board, in the context of a non-probation matter, first became aware that Respondent has been a defendant in at least two medical malpractice lawsuits since the first quarter of 2009. The lawsuits are described as follows:

A. On or about March 13, 2009, a civil complaint was filed by D[redacted] and E[redacted] B[redacted] against Respondent for medical malpractice, lack of informed consent, and loss of

consortium based on provocative lumbar discograms and microdecompressive lumbar discectomies alleged to have been performed by Respondent on D[redacted] B[redacted] on June 10, 2008, and July 22, 2008. (*D[redacted] B[redacted] et al. v. John C. Chiu, M.D. et al., Ventura County Superior Court case number 56-2009-0033954-CU-MM.*) Respondent filed a response to the B[redacted] lawsuit on May 7, 2009. Respondent filed a case management conference statement in the case on February 16, 2011. The B[redacted] lawsuit against Respondent is still pending.

B. On or about July 20, 2009, a civil complaint was filed by R[redacted] A[redacted] against Respondent for medical malpractice, lack of informed consent, and battery based on a provocative cervical discogram and microdecompressive cervical discectomy alleged to have been performed by Respondent on R[redacted] A[redacted] on a May 9, 2007. (*R[redacted] A[redacted] v. John C. Chiu, M.D. et al., Ventura County Superior Court case number 56-2009-00353459-CU-MM-VTA.*) Respondent filed a response to the A[redacted] lawsuit on October 1, 2009. He also filed a request for dismissal on May 17, 2010. A status conference in the case was set for July 15, 2011. The A[redacted] lawsuit against Respondent is still pending.

17. Respondent failed to disclose the existence of the two malpractice lawsuits, described in paragraph 16 above pursuant to an obligation to disclose all active and pending medical malpractice lawsuits against him in response to specific written and oral requests from the Board for this information. The circumstances are as follows:

A. Respondent was dishonest in written statements he made to the Board, as described further in paragraph 21 below, which is incorporated here as if set forth in full. Respondent was dishonest by answering, under penalty of perjury, "no" to the direct questions asking him to disclose pending lawsuits against him.

B. Respondent provided dishonest oral answers to questions posed by the Board's probation officers asking him if he has been sued by any patients, as described further in paragraph 23 below, which is incorporated here as if set forth in full.

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SECOND CAUSE FOR DISCIPLINE

(False Documents)

18. Respondent is subject to disciplinary action under section 2261 in that he has knowingly made or signed declarations directly related to his practice of medicine which falsely represented the nonexistence of a state of facts. The circumstances are as follows:

19. Paragraph 21 below is incorporated here as if set forth in full.

PROBATION VIOLATIONS

FIRST CAUSE FOR REVOCATION OF PROBATION

(Violation of Probation: Condition #4, Quarterly Declarations)

20. Respondent's probation is subject to revocation pursuant to probation condition four of the Probation Order because he failed to submit truthful quarterly declarations. The circumstances are as follows:

21. On or about July 6, 2010, October 1, 2010, January 3, 2011, April 1, 2011 and July 1, 2011, Respondent signed quarterly declarations under penalty of perjury for the reporting periods of April 1, 2010, through June 30, 2011. In these declarations, Respondent declared under penalty of perjury under the laws of the State of California that during the reporting period he complied with each and every term of probation. Respondent answered "no" on four different occasions to the question: "Is there any civil suit, medical malpractice, or peer review proceeding pending against you?" In fact, the two lawsuits described in paragraph 16 above were active and pending against him at the time he misstated these facts to the Board in his quarterly declarations.

SECOND CAUSE FOR REVOCATION OF PROBATION

(Violation of Probation: Condition #6, Interview with Board)

22. Respondent's probation is subject to revocation pursuant to probation condition six of the Probation Order because in interviews with his probation officer he failed to disclose, in response to direct questions, the fact that he was sued by patients B[redacted] and A[redacted] in two separate and pending lawsuits. The circumstances are as follows:

23. On or about March 3, 2010, May 20, 2010, September 15, 2010, December 20, 2010 and March 2, 2011, Respondent, who was aware at the time that he was a defendant in the two

pending medical malpractice lawsuits described in paragraph 16 above, responded in the negative to questions posed by Probation Inspector Kevin Morris asking whether Respondent had any malpractice lawsuits or complaints pending against him. The Board adopted Respondent's representations as truthful and documented them in four quarterly probation reports. In fact, the two lawsuits described in paragraph 16 above were active and pending at the time he misstated these facts to Probation Inspector Kevin Morris.

DISCIPLINE CONSIDERATIONS

24. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about July 21, 2008, in a prior disciplinary action entitled *In the Matter of the Accusation Against John Chih Chiu, M.D.* before the Medical Board of California, in Case Number 17-2002-141331, Respondent's license was placed on three years probation with terms and conditions related to failure to properly render post-operative care to two patients. That decision is now final and is incorporated by reference as if fully set forth.

23. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about August 16, 2002, in a prior disciplinary action entitled "*In the Matter of the Accusation Against John Chiu, M.D.*" before the Medical Board of California, in Case Number 05-1996-59826, the Medical Board issued a public letter of reprimand to Respondent stating that he violated Business and Professions Code section 650.1 by referring two patients to diagnostic imaging and physical therapy providers without disclosing to these patients that he had an ownership interest in these providers. That decision is now final and is incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C31784, issued to John Chih Chiu, M.D.

2. Revoking the probation that was granted by the Medical Board of California in case number 17-2002-141331 and imposing the disciplinary order that was stayed thereby revoking Physician's and Surgeon's Certificate Number C31784 issued to John Chih Chiu, M.D.

3. Revoking, suspending or denying approval of John Chih Chiu, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

4. Ordering John Chih Chiu, M.D., if placed on probation, to pay the Medical Board of California the costs of the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: July 15, 2011

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	**Case No. 17-2002-141331**
JOHN C. CHIU, M.D.,	**OAH No. L2006010232**
Physician and Surgeon's Certificate No. C31784	
Respondent.	

DECISION AFTER NONADOPTION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on September 10, 11, 12, 17, 18, 20, 24, 25, 26, 27 and 28, and October 1 and 2, 2007, in Los Angeles, California. Complainant was represented by Gloria Castro, Deputy Attorney General. John C. Chiu, M.D. (Respondent) was present and was represented by William H. Ginsburg of Peterson & Bradford, LLP, with his assistant Sherry Gregorio.

At the hearing, the Second Amended Accusation was amended as follows:

At page 5, line 20, the word "Respondent" was changed to "Dr. Shanhangian," and "he" was changed to "Dr. Chiu."

At page 6, paragraph 12, line 9, the word "and" was deleted, and the sentence stating, "A tracheostomy was performed on Donna A. by another physician," was moved to line 10, after the sentence stating, "The patient developed bradycardia and suffered a cardiac arrest at 10:35 a.m."

Oral and documentary evidence was received and argument was heard. The record was left open to allow the parties to file simultaneous closing briefs by the close of business on October 12, 2007. Complainant's Written Closing Argument and Respondent's Supplemental Brief Regarding Closing Argument were timely filed, marked as Complainant's Exhibit 47 and Respondent's Exhibit AA, respectively, and lodged. The record was closed and the matter was submitted for decision on October 15, 2007.

The Medical Board of California (Panel A) declined to adopt the proposed decision and on January 29, 2008, issued an Order of Non-Adoption and called for transcript of the administrative hearing. On May 29, 2008, the Board heard oral argument in the above-

referenced matter. Written argument was received from Complainant and Respondent, and by stipulation of the parties, exhibits 2, 17, and 24 of Respondent's written argument were struck. The time for filing written argument having expired, and the entire record, including the transcript of said hearing, having been read and duly considered pursuant to section 11517 of the Government Code, the Board hereby makes and enters the following decision and order:

FACTUAL FINDINGS

1. On December 15, 2005, the Accusation was filed. Respondent's Notice of Defense was filed on January 26, 2006. On June 22, 2007, Complainant, David T. Thornton, filed the Second Amended Accusation while acting in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On November 4, 1969, the Board issued Physician and Surgeon's Certificate Number C31784 to Respondent. Respondent's Certificate was in full force and effect at all relevant times and was scheduled to expire on August 31, 2007, unless renewed. The evidence did not disclose whether the license has been renewed. However, if the license was not renewed, the Board retains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).

Facts Re: Respondent's Treatment of Patient Donna A.[1]

3. On November 11, 2002, Donna A., a 44-year old female, was first examined by Respondent at his facility, the California Center for Minimally Invasive Spine Surgery (CCMISS). Her chief complaints were intractable, increasing neck and upper extremity pain, the left side greater than the right, left shoulder pain, headaches, middle back pain, increasing lower back and leg pain, the right leg greater than the left, with associated numbness and tingling of the right leg, foot and toes.

4. On November 11, 2002, Donna A. filled out an extensive neurological questionnaire regarding the history of her symptoms which followed a 1999 automobile accident and the ensuing treatment by several physicians. Respondent noted that the patient was taking various medications, including Effexor, Ultram, Oxycontin (discontinued the week prior), Darvon, Trazodone, and Klonopin. Respondent conducted a neurological examination of Donna A. Following that examination, Respondent diagnosed the patient with: "Herniated cervical disc with cervical radiculopathy, herniated lumbar disc with lumbar radiculopathy and high thoracic strain/disc disease." Respondent recommended magnetic resonance imaging (MRI) of the patient's cervical spine and lumbar spine for further evaluation, x-rays, and electromyography (EMG) of her right lower extremity for further assessment.

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[1] Throughout this decision, patients' initials will be used in lieu of their surnames to protect their privacy.

5. On November 11, radiologist Robert A. Princenthal, M.D., took x-rays of Donna A.'s cervical and thoracic spine and MRIs of her cervical and lumbar spine.

6. In a November 11, 2002 consultation report, under the section entitled "Recommendations," Respondent noted:

> [D]iscussed with the patient at length regarding her intractable cervical and lumbar disc symptoms, physical findings, MRI scan/EMG findings, and further alternatives of treatment and procedures of provocative cervical and lumbar discogram and microdecompressive endoscopic cervical and lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications including local anesthesia and possible conversion to general anesthesia, with possible risks and complications. She wished to go ahead with the procedures as soon as possible because of her intractable spinal disc symptoms.

7. On November 25, 2002, a medical evaluation was conducted by Dr. Duc Nguyen, M.D. to obtain pre-operative clearance for the proposed procedures on Donna A. Dr. Nguyen's November 25, 2002 report indicated that Donna A.was five feet, four inches tall, weighing 183 pounds, with a past medical history of fibromyalgia, allergic rhinitis, insomnia and depression. Dr. Nguyen cleared the patient for surgery.

8. According to a report dated November 25, 2002, Respondent conducted a further history and physical examination of Donna A. on that date. The findings in this report, signed on November 29, 2002, mirrored the majority of the findings in the November 11, 2002 examination report. Additionally, the Recommendations contained identical language to that in the November 11, 2002 report (set forth in Factual Finding 6, above). However, the November 25, 2002 report also noted that the MRI scan on November 11, 2002, revealed a three millimeter disc protrusion at C4-5 and a two millimeter "slight bulge" at C6-7. The November 25, 2007 report further noted a physical examination, in addition to the neurological examination, with the following findings:

> Blood pressure 120/80, pulse rate 84, respiration 18. She was somewhat nervous. She is mildly obese.
>
> Head, ears, eyes, nose and throat are unremarkable. Neck, slight web neck. Chest was clear. Breasts, soft without mass. Heart, normal sinus rhythm without murmur or cardiomegaly. Abdomen, mild protuberance without organomegaly. Back, please see below. Genitalia, female. Pelvic and rectal examination, per Dr. Nguyen. Extremities were intact.

9. Donna A. was admitted to Alta Monrovia Hospital on November 26, 2002, for a provocative discogram and microdecompressive endoscopic cervical discectomy with laser.

The procedures were to be performed under monitored anesthesia care (MAC) by anesthesiologist Shariar Shahangian, M.D.

10. A discogram is used to determine if injury to a particular vertebral disc is the source of a patient's pain. During a discogram, a surgical needle is inserted into a disc at the level which the physician suspects may be causing the patient's symptoms. Contrast dye is injected into the disc, and the extra fluid in the disc increases the pressure in the disc. A provocative discogram is not done under general anesthesia. It requires that the patient be awake and sedated, so that, upon insertion of the surgical needle into the disc space, the patient can confirm experiencing pain that mimics his/her pre-operative pain. Once the patient confirms replication of the pre-operative pain at a particular level, the physician can proceed with treatment, including an operation on that disc (in Donna A.'s case, by way of microdecompressive endoscopic cervical discectomy with a laser).

11. On November 26, 2002, Donna A. was moved into the operating room (OR) at approximately 9:00 a.m.[2] Dr. Shahangian gave Donna A. Versed (for relaxation) and Fentanyl (for pain tolerance), and then began administering the medication for conscious sedation.

12. At approximately 9:25 a.m., Respondent inserted a 22 to 25 gauge subcutaneous needle into Donna A.'s neck to administer local anesthesia.

13. Thereafter, at approximately 9:25 to 9:30 a.m., Respondent began to insert an 18 gauge surgical needle into Donna A.'s neck, intending to start the discogram.

14. Complainant and Respondent offered differing versions of the events that transpired from the time Respondent attempted insertion of the 18 gauge needle until Donna A. died at 11:39 a.m.

15(a). Dr. Shahangian testified that, at about 9:25 to 9:30 a.m., after Respondent had inserted the surgical needle (which Dr. Shahangian called a "trochar") into Donna A.'s neck, Dr. Shahangian observed blood coming out of the distal end in a "jetting manner indicative of [the needle] entering a major vessel." According to Dr. Shahangian, the blood was "pulsating," and he believed Respondent could have hit an artery or large vein. It was his understanding at the time of the procedure that the blood could have come from the carotid artery. However, at the administrative hearing he testified that, while the internal jugular vein is typically considered a "low pressure" vessel, it is "high pressure" compared to other veins and could "pulsate if there is some resistance to it." Dr. Shahangian stated that, after the blood pulsed out of the needle, Respondent removed the "trochar," put a sponge on the

[2] The anesthesia record was not created by Dr. Shahangian in the OR during the procedure, but was constructed several hours later, after the patient had died. Therefore, according to Dr. Shahangian, there are "some mistakes in the times" listed in the record. Consequently, the times set forth in this decision are only approximations.

skin at the site of the needle entry and held it for about five seconds before reinserting the needle in a different location. According to Dr. Shahangian, the external bleeding stopped prior to reinsertion of the needle. At this point, the patient tolerated the reinsertion of the needle and did not show any outward signs of distress, and Respondent continued his attempt to get into the cervical space. However, Dr. Shahangian noted that, within 10 to 15 minutes after the time of Respondent's reinsertion of the needle, the patient became hoarse, restless and agitated. At that time, Dr. Shahangian observed the patient's neck and did not discern any enlargement or obvious hematoma formation.[3] Nevertheless, according to Dr. Shahangian, he asked Respondent if a hematoma could be the cause of the patient's hoarseness and agitation, and Respondent purportedly stated that there was no hematoma, but that she may be experiencing an allergic reaction. Although he did not record it in the anesthesia record, Dr. Shahangian recalled that, at some point, the IV connector for administration of the conscious sedation medication became dislodged from the patient when she was thrashing around. At about 9:35 a.m. or 9:40 a.m., Dr. Shahangian administered Dexamethasone (to treat possible allergic reaction), without any effect. Dr. Shahangian did not indicate, nor did he document in his anesthesia record, what Respondent was doing during the 10 to 15 minutes after reinsertion of the needle.

15(b). Respondent testified that, in conducting a cervical discogram, he uses his right hand to insert the surgical needle after he uses his left hand to palpate the sternocleidomastoid muscle, pull back the carotid sheath (containing the cartotid artery and internal jugular vein) and apply digital pressure toward the vertebral body. According to Respondent, this creates a "valley" or a "space with no tissue," which is "almost avascular," in order to prevent injury to any blood vessel. Respondent testified that he could not conduct the provocative discogram on Donna A. because, as he began to insert the surgical needle, approximately two to four millimeters into the tissue, the patient began coughing and became restless and agitated. She also complained of pain from the needle insertion. Because she was moving, he removed the needle. He denied seeing "any significant blood" when he withdrew the needle. At some point after removal of surgical needle, Respondent recalled the patient talking to the nurses in the OR and that she sounded "squeaky." Thereafter, he heard from the nurse that the patient's IV line had been disconnected. Respondent stated that performance of the proposed discogram would have taken less than a minute using fluoroscopy.[4] However, the discogram was not performed because the needle "never got to the disc."

15(c). Complainant did not establish, by clear and convincing evidence, that blood was "flushing" or "pulsing out" of the distal end of the 18 gauge surgical needle upon insertion into Donna A.'s neck for the following reasons:

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[3] A hematoma is a localized, clotted or partially clotted collection of blood situated in tissue outside a vascular structure, usually caused by a break in the wall of a blood vessel.

[4] Fluoroscopy is an imaging technique to obtain real-time images of the internal structures of a patient.

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(1) An Accusation was filed by Complainant against Dr. Shahangian on April 20, 2004, and the matter was resolved by Stipulated Settlement and Disciplinary Order, effective April 10, 20066.[5] Following the patient's death, and through the Board's investigation of the incident and prosecution of both Dr. Shahangian and Respondent, each had an equal motive to recall the events that transpired in his favor. Therefore, Dr. Shahangian had a motive to testify in a manner consistent with his prior statements which reflected more favorably on his actions.

(2) There was no other evidence that the blood had been "flushing" or "pulsing" out of the distal end of the surgical needle upon insertion.

(3) As further set forth in Factual Findings 10, 15, 16, 20 and 27, some portions of Dr. Shahangian's are not borne out by the remainder of the evidence. Additionally, the time frame posited by Dr. Shahangian includes 10 to 15 minutes that are not accounted for. According to Dr. Shahangian, it took about 10 to 15 minutes for the patient to become hoarse and restless, which are possible indications of the formation of a hematoma.[6] However, there is no evidence regarding what took place during the 10 to 15 minutes which purportedly lapsed from reinsertion of the surgical needle until the beginning of the patient's restlessness. Respondent was supposed to be conducting the discogram, but there was no evidence that the discogram was conducted. There was no explanation regarding why, if the patient was not exhibiting outward signs of distress, the discogram did not take place in the 10 to 15 minutes following the immediate reinsertion of the surgical needle.

(4) Although autopsy photographs depicted injury to Donna A.'s right internal jugular vein, it was not established by clear and convincing evidence that the injury depicted was caused by the 18-gauge needle. (See Factual Finding 45(c) below.)

15(d). For the reasons set forth above, Respondent's recollection of the events set forth in Factual Finding 15(b) is more plausible than Dr. Shahangian's, and is incorporated as a Factual Finding herein.

16. At about 9:35 a.m. or 9:40 a.m., Dr. Shahangian administered dexamethasone (to treat possible allergic reaction), without any effect.

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[5] Effective April 10, 2007, Dr. Shahangian's Physician's and Surgeon's Certificate was fully restored to clear status, free of probation requirements.

[6] Complainant's expert, William R. Taylor, M.D., verified that it would take about 10 minutes for a hematoma to form. According to Dr. Taylor, signs of a hematoma developing in the neck include hoarseness or inability to talk, shortness of breath, gasping for air and anxiety due to inability to breathe. Additionally, one can often see a hematoma developing on the side of the neck.

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17. At approximately 9:45 a.m., Dr. Shahangian induced general anesthesia, administering propofol (to make the patient unconscious) and succynolcholine (to paralyze the muscles of the jaw and neck in order to facilitate intubation).

18(a). Dr. Shahangian testified that Respondent stated he could not continue surgery with an agitated patient and asked Dr. Shahangian to convert from MAC to general anesthesia. Although Dr. Shahangian acknowledged that a surgeon cannot perform a provocative discogram when the patient is "asleep," he insisted that Respondent did not ask him to take the patient down further into conscious sedation. Dr. Shahangian testified that he agreed to induce general anesthesia because he wanted to respect Respondent's opinion and because he believed that a hematoma may be forming and impinging on the airway and he wanted to intubate the patient, establish an airway, and provide a means of mechanical ventilation before it was obstructed. However, Dr. Shahangian was not able to intubate Donna A.

18(b). Respondent testified that, after removal of the surgical needle and hearing that the patient's IV line had been disconnected, he felt that the patient should receive further conscious sedation as prescribed, and he made that request. Respondent insisted that he requested more/deeper sedation for the patient, asking that the patient be placed in the most sedated state. However, he denied requesting general anesthesia and also denied allowing the induction of general anesthesia. Respondent explained that he uses only local anesthesia for provocative discograms, not general anesthesia. According to Respondent, he became aware that Dr. Shahangian had induced general anesthesia when he noticed that the patient was not moving at all and the anesthesiologist acknowledged that he was trying to intubate the patient.

18(c). Dr. Shahangian's testimony regarding who decided to induce general anesthesia was not credible since provocative discograms are typically performed under local anesthesia (see Factual Finding 10) and there was no evidence that the discogram had been completed or discontinued and that Respondent was continuing with the planned discectomy (see Factual Finding 15(c)(3)).

19. After inducing general anesthesia, Dr. Shahangian attempted to intubate Donna A. two to three times, using a laryngoscope, first with a Macintosh-3 blade and then a Miller blade.[7]

20(a). Dr. Shahangian testified that he was not able to visualize the epiglottis or, below that, the vocal chords, and therefore was not able to place an endotracheal tube into

[7] A laryngoscope consists of a handle with a light source and a blade to displace the tongue and epiglottis and visualize the vocal chords at the entrance of the trachea, in order to insert an endotracheal tube into the patient's trachea. There are two types of blades used on a laryngoscope. The Macintosh blade is a wider, curved blade and a Miller blade is straighter and thinner.

the trachea. According to Dr. Shahangian, there was marked distortion/swelling of the patient's airway, with "bulging" from the right side of the patient's neck, preventing him from seeing "anything as a separate entity except the base of the tongue." Dr. Shahangian continued ventilating the patient between intubation attempts, but ventilating was "getting difficult."

20(b). Dr. Shahangian's anesthesia notes, completed immediately after the patient's death, noted his observation of "marked edema and distortion of airway."[8]

20(c). Dr. Shahangian's testimony that there was "bulging" from the right side of the patient's neck was not convincing. This observation was not noted in the anesthesia record or anesthesia notes, and it was contradicted by the respiratory therapist's note, which documented that the entire circumference of the airway was narrowed, without any observations of "bulging" from the right side (see Factual Finding 27).

21. At a time undisclosed by the evidence, Dr. Shahangian was able to insert into the patient's pharynx a laryngeal mask airway (LMA), which is used when a practitioner is unable to intubate a patient.[9] When an LMA is inserted, the air takes the path of least resistance, and if the patient's anatomy is normal, the air would enter the trachea. However, Dr. Shahangian was unable to ventilate the patient using the LMA.

22. Dr. Shahangian attempted to use the LMA for about one minute, during which time he listened with a stethoscope for bilateral breath sounds and determined that ventilation was inadequate.

23. From the beginning of Dr. Shahangian's attempts to ventilate Donna A., the patient's finger was attached to a pulse oxymeter. However, Dr. Shahangian was not satisfied with the consistency of the "capture" of the patient's correct pulse by oxymetry because, at times, the machine would detect the pulse and at other times it did not. Consequently, an auxiliary pulse oxymeter was brought in and attached to another of Donna A.'s fingers.

24. At approximately 9:55 a.m., Dr. Shahangian told Respondent that it was getting difficult to ventilate the patient and that he needed Respondent to establish a surgical airway via an emergency tracheostomy. Respondent asked for a tracheostomy tray, and once it was provided, Respondent made an incision in the skin on the patient's neck. However, around 10:00 or 10:05 a.m., Respondent stopped the procedure and closed the incision in

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[8] Edema is the swelling of soft tissues as a result of excess fluid/water accumulation.

[9] An LMA is an alternative method of airway management. An LMA includes a tube with an inflatable cuff that is inserted into the pharynx. The device sits tightly over the top of the larynx and the cuff is inflated with air to create a seal.

Donna A.'s neck. Dr. Shahangian resumed with manual ventilation of the patient by way of an Ambu-bag.[10]

25(a). Dr. Shahangian testified that Respondent was unable to create a surgical airway because Respondent, by his admission, had not done tracheostomy for many years and had forgotten how perform the procedure. Dr. Shahangian testified that, despite his insistence that the procedure must be done or the patient would die, Respondent aborted the procedure.

25(b). In his testimony, Respondent admitted that, during the time he was making the skin incision, he was uneasy because he had not performed a tracheostomy for many years. Respondent also testified that the first pulse oxymeter attached to Donna A. had oxygen (O2) saturation readings of approximately 60, but that during the time he was beginning the tracheostomy, he was able to see that second pulse oxymeter showed O2 saturation of up to 98 and 100. According to Respondent, this indicated adequate ventilation and no need for continuing the tracheotomy, so he closed the incision. Respondent insisted that, at the time he stopped the tracheostomy, Donna A. was being oxygenated.

25(c). Although Donna A.'s medical records contained data strips from a pulse oxymeter indicating O2 saturation of 100 percent at 10:12 a.m., it was not established that those readings were taken from the machine which Respondent visualized during his attempted tracheostomy. Additionally, Respondent admitted that he did not know if the readings reflected the first or second machine, although he believed they were from the second because the readings reflected what he saw when the second machine was "hooked up."

25(d). In a statement given to a Board investigator on August 27, 2003, Respondent recalled problems with the pulse oxymeter readings. Based on Respondent's August 27, 2003 statement, the first pulse oxymeter was the machine with the 100 percent O2 saturation readings and those 100 percent readings were incorrect. Respondent stated, "One [pulse oxymeter] said 100 percent, and myself and my assistant [said] it's impossible [because] the patient [had not been] intubated for [so] long, so they brought another one in that showed zero percent."

25(e). Respondent's recollection of the 100 percent O2 saturation level being the sole reason for aborting the tracheostomy was not persuasive. It was not established that a reliable pulse oxymeter indicated 100 percent O2 saturation at the time Respondent attempted his tracheostomy. While one of the oxymeters may have displayed such a reading, it is questionable that Respondent would have relied upon it, given his statement that the 100 percent reading was "impossible." It is more plausible that, in his reluctance to proceed with the tracheostomy, Respondent relied upon what may have been a faulty oxymeter reading to

[10] An Ambu-bag is a hand-held device used to provide ventilation to a patient who is not breathing or who is breathing inadequately.

justify closure of the incision. It is equally plausible that Respondent is now using the faulty reading, after the fact, to justify aborting the tracheostomy, although he did not rely on the reading at the time. Regardless of when he began to rely on the O2 saturation readings as justification, the evidence established that Respondent aborted the tracheostomy based on his reluctance to perform the procedure, having not performed one for many years.

26. At approximately 10:10 a.m., a respiratory therapist, Jim Hutchison (Hutchison), was called in, by request of Respondent, to attempt intubation. At that point, Dr. Shahangian was providing manual ventilation to the patient by way of an Ambu-bag. Dr. Shahangian did not immediately allow Hutchison to do so because Dr. Shahangian believed that, according to the guidelines of the American Society of Anesthesiologists, a practitioner should limit the number of attempts at intubation, as each attempt invokes more damage to the tissue, which may lead from a partial obstruction of an airway to a complete obstruction. However, Dr. Shahangian did eventually relent and allow Hutchison to attempt intubation. In doing so, Dr. Shahangian had to stop "bagging" the patient, since Hutchison had to visualize the patient's mouth and throat.

27. Prior to attempting intubation, Hutchison noted an incision in Donna A.'s neck from Respondent's aborted tracheostomy. According to Hutchison's respiratory therapy note, when he inserted the laryngoscope into the patient's pharynx and applied upward force, he was unable to visualize the epiglottis because the "entire circumference of [the] airway [was] narrowed down at [the] level of [the] vallecula."[11] Hutchison attempted a "blind pass" of the endotracheal tube, distal and superior to the vallecula. However, upon auscultation and reading of the carbon dioxide measurements, he determined that there was no ventilation through the endotracheal tube. He continued to assist with the bag ventilation.

28. At 10:14 a.m., after Hutchison's unsuccessful attempt at intubation, Dr. Shahangian called a Code Blue, and asked the nurse supervisor to a summon a general surgeon or someone who could perform a tracheostomy.

29. Following the Code Blue, Advanced Cardiac Life Support (ACLS) efforts were undertaken by Dr. Shahangian, Hutchison and others. Thereafter, Donna A. developed bradycardia and suffered cardiac arrest prior to 10:55 a.m., at which time defibrillations began.

30. Between approximately 11:05 and 11:10 a.m., thoracic surgeon Alfonse Miguel, M.D. arrived. At 11:14 a.m., Dr. Miguel successfully performed a tracheostomy on Donna A. that provided ventilation to the patient.

31. Dr. Miguel's operative report, dated November 26, 2002, stated, *inter alia*:

> [I] opened the previous incision in the neck area and a significant

[11] The epiglottic vallecula is a depression just behind the root of the tongue between the folds in the throat.

amount of venous blood was oozing; however, this was controlled by putting pressure on the area and I was able to dissect the second tracheal ring and T slit was made and a #6 tracheostomy tube was inserted without any difficulty and then connected to ventilator. . . . The cardiopulmonary resuscitation was continued at this point and [Dr. Miguel placed a triple-lumen venous catheter].

32. ACLS efforts continued, but the patient expired at 11:39 a.m.

33(a). At the administrative hearing, the parties offered disparate evidence regarding whether Respondent remained in the OR and assisted during the ACLS efforts between 10:14 a.m. and 11:05 a.m.

33(b). Dr. Shahangian recalled that, after Hutchison's unsuccessful attempt at intubation, Respondent left the OR and did not return until about one hour later, about the time Dr. Miguel arrived.

33(c). The parties stipulated Susan Montgomery, R.N., would testify that she did not see Respondent administering chest compressions to Donna A. Nurse Montgomery was the circulating nurse and arrest team nurse for Donna A. on November 26, 2002.

33(d). In his testimony, Respondent recalled that, in response to the Code Blue, he began doing chest compressions on Donna A. until the thoracic surgeon arrived. However, in his August 27, 2003 statement to the Board investigator, Respondent never asserted that he administered chest compressions to Donna A. Instead, Respondent recalled that, with the patient "already in cardiac arrest mode," he had "just barely started [making the incision] to see if we could start a tracheostomy," when Dr. Miguel came in to take over. According to Respondent, upon making the incision, there was not much bleeding and the blood was dark.

33(e). Respondent's August 27, 2003 recollection of events was erroneous, since the evidence established that, by the time Dr. Miguel arrived, Respondent had made and closed the incision, Hutchison had attempted intubation and ACLS efforts had continued for almost an hour. However, the invalidity of Respondent's prior statement does not validate his current recollection that he administered chest compressions, particularly in light of Dr. Shahangian's recollection that Respondent left the OR and in light of nurse Montgomery's recollection, as the circulating and arrest team nurse, that she did not see Respondent administering chest compressions. Nevertheless, since Dr. Shahangian was admittedly involved in ACLS efforts, it is questionable that he was keeping track of whether Respondent was absent from the OR the entire time that ACLS was being employed.

33(f). The evidence established that Respondent did not assist during the ACLS efforts between 10:14 a.m. and 11:05 a.m. The evidence did not establish that he was absent from the OR during the entire time period from 10:14 a.m. to 11:05 a.m.

34(a). At the administrative hearing, the parties offered disparate evidence regarding whether Respondent assisted Dr. Miguel with his successful tracheostomy.

34(b). In his operative report, Dr. Miguel listed "Jae Chu, M.D." as his assistant for surgery. However, Dr. Miguel testified at the administrative hearing that Respondent did not assist him with the tracheostomy and that he only had a "glimpse" of Respondent during the procedure. He stated that, prior to performing the tracheostomy, he had no conversations with Respondent and that he did not see Respondent doing anything with the patient during the procedure. Other than Dr. Shahangian, Dr. Miguel saw no other person in the OR that he recognized to be a physician. He provided no explanation for how "Jae Chu," a name similar to "J. Chiu," would have come to be listed in his operative report as his assistant.

34(c). The parties stipulated Susan Montgomery, R.N., would testify that she did not see Respondent assisting Dr. Miguel in any way with the tracheostomy on November 26, 2002.

34(d). In his testimony, Respondent recalled assisting Dr. Miguel with the tracheostomy by sponging the blood with gauze and helping to cut sutures. He testified that he also suggested to Dr. Miguel to establish the central venous line to facilitate medication and blood administration.

34(e). The evidence established that, although Respondent was present in the OR when Dr. Miguel performed his successful tracheostomy, Respondent did not assist Dr. Miguel with that procedure.

35(a). At the administrative hearing, the parties offered disparate evidence regarding the appearance of Donna A.'s neck and any observed formation of a hematoma following the insertion and withdrawal of the 18 gauge surgical needle.

35(b). Dr. Shahangian testified, and his anesthesia notes and anesthesia record indicate, that he noticed some edema or swelling in the patient's neck. He conceded that it was diffused swelling, rather than a discrete bump, and that it was restricted to a two-inch by three-inch area around the "area of surgery," in middle of the patient's neck, toward the right side. He insisted that the swelling was compatible with a hematoma near the surgical site, which was not profound but later became bigger.

35(c). Respondent testified that there was no change in the patient's neck after he removed the needle from her neck and that he did not believe a hematoma was forming. He insisted that, from the time he removed the needle until Dr. Miguel arrived, he did not see any discrete, significant hematoma at the level of the larynx and around the trachea. He also did not recall any swelling in her neck, but noted that the patient's neck was "always fat and short."

35(d). Dr. Miguel testified that, prior to performing his tracheostomy, he assessed Donna A.'s neck and noted a significant amount of swelling in the neck. He recalled that the

neck was markedly swollen "by some type of edema or bleeding into the area." Although a cricothyrotomy[12] would have been "faster" to perform, there was so much swelling that he could not determine where the cricothyroid membrane was, so he decided to perform a tracheostomy by opening the prior incision. During his testimony, when asked if he observed any evidence of a hematoma, he stated that, once he opened the incision, "a lot" of dark blood came oozing out of the wound.

35(e). The evidence established that there was edema / swelling in Donna A.'s neck following the reinsertion of the 18 gauge surgical needle. However, Complainant did not establish, by clear and convincing evidence, that anybody ever observed a discrete hematoma developing in Donna A.'s neck as a result of the insertion of the surgical needle (See also, Factual Finding 46, below).

36. None of the witnesses (Dr. Shahangian, Hutchison, Dr. Miguel and Respondent) observed any deformity, distortion or displacement of the trachea. Additionally, none of them noted any evidence of tracheomalacia (tracheal collapse).

37. Following Donna A.'s death, the case was referred to the Los Angeles County Coroner's (Coroner) office. The case was assigned to Susan Selser, M.D., who conducted the autopsy on December 1, 2002.

38. In the records forwarded to the Coroner's office was Respondent's OR note, which stated, "[Patient] was extremely restless under local and MAC anesthesia while beginning discogram (or insertion of needle)."

39(a). Dr. Selser issued an autopsy report on March 11, 2003. That report indicated the following:

> Neck Dissection:
> [R]ather extensive hemorrhage and early decomposition change are present. No edema is noted along the larynx. . . . There is abundant hemorrhage along the posterior soft tissues of the pharynx and strap muscles. . . . The tongue on section shows focal areas of lateral hemorrhage, small.
>
> [¶ . . .¶]
>
> Diagnoses [from Microscopic Report]:
>
> Large submucosal hemorrhage in multiple sections of the posterior pharynx with mucosal disruption. . . .

[12] A cricothyrotomy is an emergency incision through the skin and cricothyroid membrane to secure a patient's airway.

39(b). In her March 11, 2003 report, Dr. Selser did not note any damage to the patient's right internal jugular vein. However, autopsy pictures were taken of the right and left internal jugular veins depicting some injury to the right internal jugular vein and hemorrhage in that area.

39(c). An anesthesiology consult by a Dr. Hendrickson, dated February 3, 2003, and contained in the March 11, 2003 report noted, among other things:

> [A] surgical needle was inserted by the surgeon and reported to bleed somewhat. . . .
>
> 0925 she was agitated, hoarse, coughing, restless, and was given Dexamethasone, lidocaine, and 50 mg propofol. 02 Sat 99. There was no visible edema.
>
> 0950 MAC was converted to general anesthesia with lidocaine 30 mg, propofol 100 mg, succinylcholine 180 mg. . . . She could not be intubated, nor ventilated with LMA; efforts by MD and RT. There was marked edema and distortion of the airway; the epiglottis could not be seen.
>
> Tracheostomy was attempted, but there was much blood in the anterior neck, and it was unsuccessful. . . .
>
> [¶ . . .¶]
>
> IMPRESSION:
>
> 1. Inability to establish an airway in a person of body habitus associated with high anterior larynx, very short neck (?webbed), anterior cervical curvature, full set of teeth, and obesity.
>
> 2. What caused the original airway problem? ? allergy, response to pain, momentary loss of airway patency? I don't know. Drugs usage was appropriate.

39(d). Dr. Selser's opinion, stated in the March 11, 2003 autopsy report was that, "[t]he cause of death is cardiorespiratory arrest due to failure to establish airway due to short neck (web neck) obesity."

40. After reading the March 11, 2003 autopsy report, Dr. Shahangian called the Coroner's office to discuss the contents of that report. Dr. Shahangian spoke with a man who was a "Director or Chair" at the Coroner's office, and he also wrote a letter to the Coroner on April 23, 2003. Dr. Shahangian informed the Coroner that he believed their office had not been informed that the patient's surgery had commenced and that they had the

erroneous impression that he had decided to induce general anesthesia without any previous surgical attempt. He further informed the Coroner that, when the examiner had seen the patient's neck, it was not in the same state as it was previously, when a "huge hematoma" had been present. Dr. Shahangian explained the chain of events as he recalled them and stated that forceful intubation was unlikely to cause retropharyngeal hemorrhage without signs of trauma in other areas, including the esophagus.[13]

41(a) Dr. Selser completed a supplemental autopsy report on May 7, 2003, following additional information received in Dr. Shahangian's April 23, 2003 letter. This supplemental autopsy report was included in the final Coroner's case report, issued after May 7, 2003.

41(b). Dr. Selser's supplemental autopsy report stated:

> From the clinical circumstances reported it is apparent a significant hematoma was developing in the neck prior to intubation/resuscitation efforts. The apparent trauma of the right internal jugular vein, see autopsy photos, appears consistent with the source of the bleeding.
>
> It is likely the resultant evolving hematoma complicated efforts at airway placement, see supplemental anesthesiology consultant report of Dr. Hendrickson, 4-29-03.
>
> The Death Certificate has been amended to reflect this additional factor in the death as reflected above.

41(c). Also contained in the Final Coroner's Report was a supplemental anesthesiology report, dated April 29, 2003, which stated:

> This supplemental anesthesiology report is to add to the original anesthesiology report signed on February 3, 2003.
>
> From information received today from the Deputy Medical Examiner, Dr. Susan Selser and Chief Medical Examiner-Coroner, Dr. Lakshmanan Sathyavagiswaran, the following information is added to the original report under IMPRESSION, paragraph #2.
>
> > "A large hematoma formed in the right neck after insertion of a surgical needle. This caused external pressure on the airway, with difficulty in the airway management by LMA, by intubation, and by tracheostomy."

[13] In his testimony, Dr. Shahangian continued his assertion that he did not tear the posterior pharynx and insisted that he "had nothing to do with the posterior pharynx."

41(d). In the Final Coronor's Report, the patient's cause of death was changed to cardiorespiratory arrest due to failure to establish an airway due to short neck (web neck), obesity and neck hematoma.

42. Contrary to Dr. Shahangian's claim that the Coroner did not know about the commencement of surgery, the initial anesthesiology consult noted the needle insertion and observation of blood. The anesthesiology consult also mentioned the patient's agitation, hoarseness, coughing and restlessness, and the marked edema and distortion of the airway, yet the consulting anesthesiologist did not independently conclude, or even suggest, that a hematoma may have formed. Additionally, although photographs were taken of the right internal jugular vein showing some injury and hemorrhage in that area, Dr. Selser did not mention it in her initial report. The amended findings in the Final Coroner's Report were based on the assertions by Dr. Shahangian, and not on any independent assessment by the consulting anesthesiologist or Dr. Selser, that a hematoma may have formed in the patient's neck. Since Dr. Shahangian's assertions, as well his motives in providing the information to the Coroner, were questionable, the amended findings in the Final Autopsy Report are given less weight than those in the March 11, 2003 autopsy report.

43. In Donna A.'s initial Certificate of Death, issued December 3, 2002, the cause of death was listed as "deferred." On February 13, 2003, an amendment to the death certificate (amended death certificate) was issued, and the cause of death was listed as "cardiorespiratory arrest, failure to establish airway and short neck (web neck) obesity." The amended death certificate indicated that the November 26, 2002 operation had "not yet" been performed, but that there was the "beginning of general anesthesia." The amended death certificate also listed the "events which resulted in injury" as "unable to establish airway."

44. On July 7, 2003, Donna A.'s death certificate (final death certificate) was again amended to reflect the cause of death as cardiorespiratory arrest, failure to establish airway, short neck (web neck) obesity and neck hematoma. In the section regarding whether the operation had been performed, the final death certificate indicated that there had been "trochar placement for attempted cervical discogram." The final death certificate also listed the "events which resulted in injury" as "unable to establish airway following attempted trochar placement.

45(a). At the administrative hearing, Dr. Selser testified credibly that she observed mucosal disruption above Donna A.'s airway and that the whole area was hemorrhagic, confluent in the back of the pharynx and lateral sides of neck and also around the injury of the internal jugular vein. Dr. Selser opined that the extensive trauma to the mucosa in the retropharyngeal area and the extensive bleeding in that area was probably related to the difficult intubation efforts.

45(b). At the time of autopsy, Dr. Selser did not, and could not, observe any deviation of the patient's airway caused by a hematoma. She could not opine regarding any deformation, distortion or displacement of the trachea since, upon dissection, the original

integrity of organs was disturbed, and she was unable to see the neck *in situ* in order to determine what had existed before.

45(c). Dr. Selser explained that she did not describe the disruptions in the right internal jugular vein in her original autopsy report because she did not think it was an injury at the time. According to Dr. Selser, it was clear that there was extensive blood in the area which was not supposed to be there. She was "struck by the hemorrhage" and "disturbed by what it meant." However, at time of autopsy, she believed that nothing had been placed into the patient's neck. Therefore, her focus was on what happened during intubation efforts and the inability to save the patient. She was later made aware that a needle had been placed in the patient's neck and that the "difficulty" with the patient began before intubation and resuscitation attempts. Dr. Selser could not determine from the autopsy alone where the blood came from, but needed to put her findings together with the time sequences provided to her. Based on her autopsy findings, her review of all records, including Dr. Miguel's report, and the input from Dr. Shahangian, Dr. Selser determined that the blood she found had most likely come from the injury she observed in right internal jugular vein. However, Dr. Selser could not rule out that Respondent's attempt at a tracheostomy created the blood in the patient's neck. She also could not rule out that Dr. Miguel's incision caused some of the bleeding. She conceded that the blood could be related to resuscitative efforts and that it was not possible, at time of autopsy, to separate those out.

45(d). Dr. Selser did not testify that the injury to the right internal jugular vein and the hemorrhage observed was evidence of a previously-existing hematoma.

46(a). At the administrative hearing, Respondent offered the credible testimonies of William Klein, M.D., a pulmonary disease specialist; Richard Ruffalo, M.D., an anesthesiologist; Martin Krell, M.D., a neurosurgeon; and Vert Mooney, M.D., an orthopedic surgeon, to testify regarding the likelihood of a hematoma forming in a patient's neck following the puncturing of the internal jugular vein and the likelihood that any such hematoma would deviate the trachea. Their testimonies collectively established Factual Findings 46(b) through 46(f).

46(b). It is very unlikely that a hematoma large enough to deviate the trachea could result from a puncture of the internal jugular vein by an 18 gauge needle. The carotid artery and the internal jugular vein are encased in the carotid sheath and surrounded by the sternocleidomastoid and other smaller muscles, which are, in turn, surrounded by fascia, then fatty/subcutaneous tissue and then skin. The muscles, fascia and fat help to stop the formation of hematomas around the internal jugular vein by applying natural pressure, or "tamponade," against the already low pressure system of the vein, which aids in clot formation. A nick of the internal jugular vein could leak for about 10 minutes, but then "tamponade" would take effect. While hematomas can sometimes form from a nick to the internal jugular vein, they typically create only a slight bulging from one to two and one half centimeters in diameter, and they are never large enough to deviate, deform or collapse the trachea.

46(c). The patient's symptoms did not demonstrate the formation of a hematoma which deviated, deformed or collapsed her trachea. At time the 18 gauge needle was removed from her neck and the patient was talking to the nurses, there was no evidence of any hematoma formation. Since the patient was able to talk and, therefore, able to breathe after the needle was removed, she was in no respiratory distress at that time. Additionally, none of the records indicate that she complained of not being able to breathe at any time prior to being placed under general anesthesia. If a trachea is blocked, displaced or collapsed, this can create "stridor," which is a deep, throaty sound, or squeaky noises, or wheezes. There was no evidence of any stridor or wheezing in the patient's records. While the patient's voice was described as hoarse and "squeaky," this alone did not indicate the formation of hematoma that was displacing her trachea. The hoarseness can be attributed to factors other than a hematoma, such as post-nasal drip.[14] Moreover, the hoarseness or squeakiness in her voice coincided with a time when her blood saturation and heart rate were normal, which would not indicate any problem with her airway. There was never any evidence of a hematoma in the laryngeal area, created by the surgical needle, which distorted the patient's trachea and made it difficult or impossible to ventilate the patient.

46(d). There was never any evidence of a hematoma in the retropharyngeal area causing the concentric narrowing that made it impossible for Dr. Shahangian to intubate the patient. It is anatomically impossible for hemorrhage from the low pressure internal jugular vein, caused by insertion of an 18 gauge needle at the C4-C5 level, to travel to the retropharyngeal area, because that would require several hours of continuous bleeding, which would not occur due to the pressure of the surrounding fascia and muscles. The fascia and muscles would also act as barriers to the blood flowing back upward. Additionally, even if a hematoma was able to work its way up, it would dissipate as it traveled. Instead, the edema and hemorrhage that were found in the retropharyngeal area came from the intubation efforts of Dr. Shahangian. (See also Selser opinion in Factual Finding 45(a).) When a laryngoscope blade touches the retropharynx, it traumatizes the sensitive tissue and can cause more edema and hemorrhage with each successive intubation effort. Multiple attempts may cause a narrowing of the airway which makes subsequent attempts at intubation virtually impossible.

46(e). It is implausible that the lacerations to the internal jugular vein noted by Dr. Selser were caused by the 18 gauge needle.

46(f). While a hematoma may have formed in Donna A.'s neck, this occurred after Respondent's initial tracheostomy attempt. When performing a tracheostomy, the surgeon must cut through arteries and veins, which can cause significant bleeding. Therefore, the

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[14] In coming to their conclusions, Respondent's experts relied on the deposition testimony of OR nurses Anne Dale and Susan Montgomery that, contemporaneous with her coughing and restlessness, Donna A. stated that she had post nasal drip and wanted to irrigate her sinuses prior to surgery, but was not allowed. The experts' reliance on these deposition testimonies was reasonable, given Donna A.'s history of allergic rhinitis (See Factual Finding 7).

accumulation of blood observed by Dr. Miguel was probably caused by Respondent's prior tracheostomy attempt. However, it is unlikely that any hematoma following Respondent's attempted tracheostomy caused deformation of the trachea. In an obese person, lying on her back, the airway can collapse on itself, but not the trachea. The cartilage surrounding the trachea keeps the trachea open, and it takes tremendous pressure to collapse it.

47(a). In the Second Amended Accusation, page 5, paragraph 11, lines 19 through 21, Complainant alleged,

> Within ten minutes, the patient began coughing and became hoarse, agitated and restless due to a hematoma developing in her neck. Dr. Shahangian reported that when Dr. Chiu withdrew the needle from Donna A.'s neck, "blood was flushing out."

47(b). Complainant did not establish, by clear and convincing evidence, that blood was "flushing out" of the needle when Respondent withdrew it from Donna A.'s neck or that the patient's agitation was due to a hematoma developing in her neck.

48(a). In the Second Amended Accusation, page 6, paragraph 14, lines 23 through 26, and paragraph 15, line 28, Complainant alleged,

> [Respondent's] decision to allow the induction of general anesthesia in response to Donna A.'s coughing and her becoming hoarse, agitated and restless and her developing hematoma departed from the standard of care. . . .

> [R] Respondent deviated from the standard of care by inducing general anesthesia. . . ,

48(b). Complainant did not establish, by clear and convincing evidence, that Respondent made the decision to allow the induction of general anesthesia or that he "induced general anesthesia."

Facts Re: Respondent's Treatment of Patient John C.

49. Patient John C., a 79-year-old male, was first seen by Respondent on May 31, 2002. His chief complaint was intractable and increasing low back and leg pain, with the left leg pain greater than right leg pain. John C. had a medical history which included two heart bypass surgeries in 1975 and 1985, gallbladder and appendix surgeries, cervical laminectomies in 1972 and 1997, angioplasty in 2001, and pulmonary embolism in 2002.

50. According to Respondent's May 31, 2002 consultation report, he conducted a neurological examination of John C. on that date which revealed the following:

He was in distress from spinal pain. There was paralumbar vertebral muscle tenderness and muscle spasm at +1 to 2 with -1to 2 limitation of low back movement. Straight leg raising was 75° on the right and 65° on the left. Ankle jerk was +1 bilaterally. Pain and touch sensation was -1 to 2 for dorsal and lateral aspect of the left foot and ankle.

[¶] . . . [¶]

Muscle strength was grossly intact. Gait was normal. Tandem was normal. Alternate movement rates and coordination were good.

51. On May 31, 2002, Respondent diagnosed John C. with degenerative lumbar disk disease, with stenosis and radiculopathy. Respondent's recommendations included the following:

1. X-rays of appropriate areas for assessment;
2. Updated MRI scan of lumbar spine for further evaluation;
3. CT scan of lumbar spine for further evaluation;
4. EMG of bilateral lower extremities for further assessment . . ."

I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms/herniation/spondylosis with lumbar radiculopathy symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedures of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications.

52. On May 31, 2002, an EMG of John C's lower extremities revealed bilatereal radiculopathy at L5 and left S1 radiculopathy. A CT scan of his lumbar spine taken the same day revealed the following:

1. L1-2: broad 1-2mm disc protrusion.
2. L2-3: broad 1-2 mm disc protrusion.
3. L3-4: 3 mm disc protrusion extending into both neural foraminal exit zones, left greater than right.
4. L4-5: 4-5 mm disc protrusion with grade 2 spondylolisthesis.
5. L5-S1: 4mm disc protrusion.

53. On June 7, 2002, x-rays were taken of John C.'s lumbar spine.

54. On August 6, 2002, an MRI was performed on John C.'s thoracolumbar spine by Robert Princenthal, M.D. of Medical Imaging Medical Group. His impressions were:

1. Severe degenerative facet joint changes L4-5 resulting in a 2-3 mm anterolisthsiasis [*sic*] of L4-5 and contributing to a moderate central canal stenosis.
2. 3-MM, perhaps 4-MM central and slightly left paracentral disc protrusion at L5-S1 encroaching on the lateral recess on the left.
3. Minimal disc bulge L1-2 centrally (2-MM).

55. On August 15, 2002, Respondent conducted a preoperative history and physical on John C. Respondent's August 15, 2002 history and physical examination report documented Respondent's review of the May 31, 2002 EMG findings and the findings from the patient's September 6, 2001 MRI of his lumbosacral spine, which indicated a history of low back pain and right leg pain and the following impressions:

1. Grade I degenerative spondylolisthesis with moderately severe right latereal recess/proximal foraminal stenosis at L4-5 and mild central canal stenosis also present at this level.
2. Osteoarthritic facet joints also present at L5-S1 with prominent left lateral recess and foraminal stenosis present at this level.
3. Small generalized disc bulge at L1-2.

56(a). Respondent's August 15, 2002 neurological examination produced findings identical to those from the May 31, 2002 examination. In the Recommendations section of the August 15, 2002 report, Respondent noted:

> I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms/herniation/spondylosis with lumbar radiculopathy symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedures of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications. They wished to go ahead with the surgery immediately because of severe intractable symptoms.

56(b). Respondent's uncontradicted testimony established that, although he did not list all of the alternatives, risks and complications of the procedures in his report, he did discuss them with the patient. In addition to his discussion with the patient, he had pamphlets and books available regarding risks and complications of the procedures, and that he had a brochure available on the Internet as well.

57(a). On August 16, 2002, John C. was admitted to Pacific Hospial in Long Beach, California. Respondent performed a provocative lumbar discogram and a microdecompressive endoscopic lumbar discectomy with laser thermodiskoplasty. Respondent's August 16, 2002 operative report indicated that local/MAC anesthesia was used for these procedures. The operative report contained a description of the operation, which included the following:

> [A]fter regular prep and drape and under .5% local Xylocaine anesthesia, provocative lumbar discogram of L3, L4 was performed with left posterolateral approach and L5 with left transpinal approach with 3 cc. Ominipaque dye injected under digital pressure with positive reproduction of preoperative pain and abnormal discogram of L3, L4 and L5 noted.

57(b). At the administrative hearing, Respondent asserted that the operative report documented the patient's level of consciousness, since it indicated that local/MAC anesthesia was used and it indicated that the patient was awake and able to respond. He noted that the phrase "positive reproduction of preoperative pain" means that the patient responded verbally, confirmed that he felt pain and described the pain.

57(c). There was no evidence to contradict Respondent's assertion that John C. responded verbally, confirmed that he felt pain and described the pain.

58. John C. was discharged from Pacific Hospital on August 16, 2002.

59. John C. visited Respondent's office on August 29, 2002. In an August 29, 2002 progress note, Respondent documented that the patient's left leg pain was better and that there was no lower back pain or numbness. He noted that the patient's right leg pain was continuing and that the patient experienced a "slight right limp at times." He also noted that the patient was "ambulating – ok." Straight leg raising (SLR) tests conducted that day produced findings of "75°/75°." Respondent prescribed Neurontin and bilateral sacroiliac (SI) joint trigger point injections and recommended that the patient return in three weeks.

60. The SI trigger point injections were administered on August 29, 2002. X-rays of John C.'s lumbosacral spine, taken that same day, revealed "degenerative change at L4-5 and L5-S1 with grade 1 anterolisthesis of L4 in reference to L5."

61. On September 17, 2002, John C. returned to Respondent's office. Respondent's progress note from that date noted that the patient's right leg pain was continuing. SLR tests conducted that day revealed the same findings as on August 29, 2002. Respondent prescribed Neurontin, an EMG on the patient's right leg for evaluation, SI joint trigger point injections, and a CT scan of the patient's lumbar spine for assessment. Respondent recommended that the patient return in three weeks.

62. On September 17, 2002, SI trigger point injections were administered. The recommended EMG was conducted, with the following findings: "Findings are commensurate with right L5 radiculopathy. Clinical correlation is suggested for these findings." A CT scan was also conducted, with the following findings and impression:

> FINDINGS:

[L]4-5: Broad based 4-5 mm disc is again identified extending into both lateral recesses. Again noted is a bilateral spondylolisthesis with minimal subluxation.

L3-4: 2-3 mm biforaminal disc bulges are seen peripherally left greater than right. This extends into the left lateral recess with mild involvement of the left exiting L3 nerve root.

L2-3: Biforaminal 2-mm bulges are noted extending into the lateral process.

L10-2: 2-mm annular bulge is seen in midline.

[¶] . . . [¶]

IMPRESSION:

Findings show similar changes to the prior MR. Pertinent large discs are seen at L4-5 and L5-S1. Facet joint hypertrophic spurring and spondylolysis is seen at the L4-5 level. There is evidence of spondylolysis particularly on the left at L5 contributing to this finding. Biforaminal discs are seen at L3-4 and L2-3.

63. At the administrative hearing, Respondent maintained that he addressed appropriately any new neurological findings reported by John C. following the operation. Respondent asserted that John C. did not have a "foot drop" when he saw him, that neither the August 29 or September 17, 2002 notes documents a foot drop, and that the patient did not complain of that problem until after he had left Respondent's care.

64. Respondent contended that he did not recommend an MRI on August 29 or September 17, 2002, because the patient did not want an MRI and because the patient was an older man who "cannot tolerate an MRI of that length of time." Respondent noted that an MRI takes 20 to 30 minutes, during which the patient must be lying down, and that a CT scan takes only five minutes. However, Respondent's position is belied by the fact that John C. could tolerate undergoing an MRI, and had tolerated MRIs on September 6, 2001, and August 6, 2002. John C. also tolerated an MRI on October 3, 2002, after leaving Respondent's care. Consequently, the evidence established that an MRI was a viable option available for Respondent to recommend.

65(a). In the Second Amended Accusation, page 9, paragraph 27, lines 18 through 21, Complainant alleged,

> The standard of care required that Respondent document all post-operative checks in the patient's chart. Respondent failed to document

the patient's post operative visits on August 29, 2002 and September 17, 2002, and thereby departed from the standard of care.

65(b). When Respondent originally produced John C.'s records to the Board, they did not contain the progress notes from the August 29 and September 17, 2002 visits, and some other prior visits. Respondent explained that he had employed his staff and his attorney to send copies of John C.'s chart to the Board, but that he subsequently discovered that part of chart had not been sent. In his office, one side of the patient's file is used to hold the clinical charts and one side is used to hold the business/insurance documents. The August 29 and September 17, 2002 notes had inadvertently been placed on the business/insurance side of the chart, which was not produced to the Board. When Respondent discovered this error, he produced the additional chart documents to the Board. These additional documents were contained in Complainant's exhibits at the hearing and used, in part, to establish the facts set forth in Factual Findings 59 and 61, above.

65(c). Complainant did not establish, by clear and convincing evidence, that Respondent failed to document the patient's post operative visits on August 29, 2002 and September 17, 2002.

Facts Re: Respondent's Treatment of Patient Steve F.

66. Steve F. was first seen by Respondent on January 22, 2001, after traveling from his home in Madera, California to Respondent's office in Thousand Oaks. Steve F. sought a consultation with Respondent because he had been spending weeks in bed due to pain down one of his legs which prevented him from doing his work. At that first visit, Steve F. complained of lower back pain. Respondent conducted an examination and reviewed the patient's prior MRI scan films dated December 27, 2000. Respondent ordered an EMG, which was performed that same day.[15] The EMG revealed radiculopathy on the left at L5-S1. Respondent diagnosed Steve F. with herniated lumbar discs with lumbar spondylosis and lumbar radiculopathy. On that day, Respondent also ordered an MRI of the pelvis and retroperitoneal area.[16] Respondent recommended that Steve F. undergo a discogram followed by an endoscopic discectomy with laser.[17]

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[15] The medical records indicate that the January 22, 2001 EMG was signed by Dr. Thomas Clifford and cc'd to Guy Rogers, D.C. In their testimonies at the administrative hearing, Steve F. and his wife Susan F. were adamant that Dr. Clifford never performed a test on Steve F. Instead they recalled the EMG being performed by a chiropractor named Dr. Rogers. They recalled Respondent introducing them to Dr. Clifford, but that meeting lasted only 10 seconds. The evidence did not contradict their testimonies.

[16] The MRI was performed on January 27, 2001, with normal findings.

[17] The medical records indicate that Respondent administered bilateral nerve blocks at L4, L5 and S1. However, in his testimony at the administrative hearing, Steve F. did not recall receiving this treatment.

67. In a January 2, 2001 Neurological Evaluation report, Respondent stated:

> I discussed with the patient at length regarding his intractable lumbar disc symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedure of provocative lumbar discogram first for confirmation prior to microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty, and its possible risks and complications. He wished to go ahead with the procedure due to his severe intractable lumbar symptoms.

68. Steve F. signed an Informed Consent form, dated February 2, 2001, consenting to the lumbar discogram and lumbar discectomy, which indicated:

> I have been informed that there are certain risks in the operation(s) and complications may occur at surgery and in the post operative period. I have been fully informed of the nature of the surgery and the purpose for which it is performed. I have been informed of other alternative methods of treatment.

69. A History and Physical Examination Report, dated February 7, 2001, mirrored the findings in the January 22, 2001 Neurological Evaluation Report. The Recommendations section of the History and Physical Examination Report indicated:

> I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the surgery of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty, and possible risks and complications. They wished to go ahead with the surgery because of severe, intractable symptoms.

70(a). At the administrative hearing, Respondent maintained that he discusses the alternatives, risks and complications of the procedures with patients and that the patients are shown a film before they decide to proceed with the recommended treatment.

70(b). Steve F. insisted that Respondent did not tell him about any possible risks, complications or alternatives of the procedures. Respondent definitely did not tell him that he could suffer from an infection, hematoma, vascular injury, nerve damage, being operated on the wrong level, soft tissue injuries. Steve F.'s wife, Susan F. confirmed in her testimony that Respondent did not tell them that one of the complications of procedure was infection. Steve F. testified that Respondent said that he could make him well, that the procedure was simple and that there were no complications. Steve F. did not recall reading the informed consent forms before signing them.

///

70(c). Steve F.'s testimony that Respondent told him that there were "no complications" from the procedure was not credible and appears to be an exaggeration. It seems very unlikely that Respondent would have made such brash assertion, particularly given his attempts to document the patient's informed consent. Nevertheless, it is credible that Steve F. was not informed of all of the risks, complications and alternatives of the procedures. Despite Steve F.'s signature on two informed consent forms (See Factual Findings 68 and 73), generally confirming that he had been informed of the risks, complications and alternatives to the proposed procedures, none of the evidence established what risks, complications and alternatives, if any, Steve F. was advised about. None of these risks, complications or alternatives was listed on either form (other than the risk of fatality noted on the hospital consent form) or in Respondent's January 22 or February 7, 2001 forms. While the standard of care may not require the listing of all of the risks, complications or alternatives in these documents, the absence of such an enumeration of what specifically was discussed allows more weight to be given Steve F.s assertion that he was not informed of all of the risks, complications and alternatives of the procedures.

70(d). The evidence established Steve F. was not informed of all of the risks, complications and alternatives associated with a provocative lumbar discogram and endoscopic discectomy.

71(a). Complainant alleged in the Second Amended Accusation, paragraph 31, page 11, lines 1 through 3, that "Respondent did not advise Steve F. of the risks and benefits associated with a provocative lumbar discogram and endoscopic diskectomy. This discussion is not documented in the medical record."

71(b). Although Complainant did establish, by clear and convincing evidence, that Respondent did not advise Steve F. of all of the risks and benefits associated with a provocative lumbar discogram and endoscopic discectomy, Complainant did not establish that such a discussion "is not documented in the medical record." Such a discussion was documented, although it was not proven that it took place as described.

72. On February 8, 2001, Steve F. traveled from his home in Madera to Simi Valley to undergo the planned procedure at the Simi Health Center.

73. On that date, Steve F. also signed an informed consent on a Simi Health Center form, consenting to performance of the lumbar discectomy at the Simi Health Center. This form stated:

> I have been informed that there are certain risks in the operation(s) and complications may occur at surgery and in the post operative period. These complications may be serious or fatal. I have been fully informed of the nature of the surgery and the purpose for which it is performed. I have been informed of other alternative methods of treatment.

74. The Simi Health Center anesthesia record indicates that anesthesia began at 10:30 a.m. and ended at 2:40 p.m., and that the procedure began at 10:55 a.m. and ended at 2:10 p.m. Respondent's February 8, 2001 operative report indicated that Local/MAC anesthesia was used. The operative report contained a description of the operation, which included the following:

> [A]fter regular prep and drape and under .5% local Xylocaine anesthesia, provocative lumbar discogram of L2, L3 and L4 was performed with posterolateral approach with with 3 cc. Ominipaque dye injected under digital pressure with positive reproduction of preoperative pain and abnormal discogram of L2, L3 and L4 noted.

75(a). Looking at the February 8, 2001 report's indication of "positive reproduction of preoperative pain," Respondent testified that this indicates that the patient was able to talk to him and that, from the patient's oral responses, he was able to reproduce preoperative pain.

75(b). Steve F. testified that he did not have any conversation with anyone during the procedure. He noted that he may have said something to the anesthesiologist when she placed a needle in his arm, but that was the only conversation he had. He insisted that he did not answer any questions regarding the replication of his pain, or anything to that effect.[18]

75(c). Steve F. also maintained that, despite Respondent's assurances that the procedure would be performed under local anesthesia, this was not what occurred. According to Steve F., "they knocked me out at some point in time, which was not our agreement." Steve F.'s wife, Susan F. also testified that, the procedure took longer than anticipated and that when she asked Respondent about this after the procedure, he informed her that they had to use general anesthesia. However, the anesthesia record from Simi Health Center indicated only the use of MAC, without general anesthesia.

75(d). The clear and convincing evidence established that Respondent did not have intra-operative discussions with Steve F. during the provocative discogram. Respondent did not testify that he had an independent recollection of the intra-operative discussion with Steve F. Given his documentation of other conversations which did not necessarily take place as described (See Factual Findings 70 and 71), Respondent's insistence that an intra-operative conversation took place is given less weight than Steve F.'s independent recollection of no intra-operative conversations.

76. On February 8, 2001, Steve F. was discharged from Simi Health Center after 4:30 p.m. Steve F. walked out of the hospital and stayed overnight at one of the motels recommended by Respondent's office staff. Susan F. obtained the Vicodin that Respondent had prescribed for relief of post operative pain, and Steve F. began taking that medication.

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[18]There was no evidence that the MAC may have had any affect on the patient's ability to recall any intra-operative discussions.

77(a). A document entitled Same Day Discharge Instructions was contained in Steve F.'s medical records. That document included the following instruction:

> You should see Dr. ____tonight_____ on ___2-8-01___
> Alert your physician if you have:
> Persistent/abdominal bleeding — Continuous or severe pain
> Difficulty Breathing — Persistent nausea and/or vomiting
> A fever or chills — Difficulty urinating

77(b). Instead of specifying a doctor's name in the appropriate blank, the word "tonight" was inserted. No specific doctor was identified as the physician to see on February 8, 2001.

78(a). Steve F. and Susan F. testified that, when they left Simi Health Center, no post operative appointments had been set by Respondent's staff. Steve F. and Susan F. both testified that, on the night of February 8, 2001, Steve F. did not return to see Respondent or any of Respondent's colleagues.

78(b). Respondent asserted that, on February 9, 2001, Steve F. returned to Respondent's office, that Respondent examined him and that a post-operative x-ray was taken. During his testimony, Respondent pointed to a February 8, 2001 progress note and a February 8, 2001 x-ray as support for his assertion that Steve F. returned for a post operative examination that night. However, this assertion is not persuasive, for the following reasons:

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(1). A February 8, 2001 progress note was contained in Steve. F's records and produced by Respondent to the Board. The note indicated that "post surgery," the patient was "doing well" with "no complaints," and that a neurological examination was conducted. The February 8, 2001 progress note was placed on the same page as, and just below, a February 2, 2001 pre-operative progress note. However, none of Respondent's other progress notes admitted into evidence combine more than one day's notes on a page. Instead, for all the other progress notes, the note for each date is on a separate piece of paper. Consequently, the February 8, 2001 entry appears to be a later-added note and is suspect. It cannot be relied upon to establish that a post surgery exam was conducted on Steve F. on the night of February 8, 2001, after he had been discharged from the hospital.

(2). Contained in Steve F.'s medical records is an x-ray report, dated February 8, 2001, entitled "Lumbar Spine, Two Views, Post Op." There is no indication of the time the x-rays were taken. Neither Steven F. nor his wife recalls any post-operative x-rays being taken after Steve F. left the hospital. Therefore, the x-ray report cannot be relied upon to establish that a post surgery examination was conducted on Steve F. on the night of February 8, 2001, after he had been discharged from the hospital.

79. On February 9, 2001, Steve F. and his wife returned home to Madera. He began to experience severe pain, and by February 11, 2001, he was in so much pain that he

could not get out of bed. Between February 11 and 19, 2001, Steve F. remained in bed with continually increasing pain and nausea.

80. On February 12, 2001, Steve F.'s wife called Respondent's office several times to find out what to do for Steve F.'s pain. Respondent prescribed Dexamethasone and Ranitidine, and Susan F. picked up the phoned-in prescriptions at the Longs Drugs near her home. The Longs Drugs records indicate that the prescribing physician was "J. Chiu."

81. On the morning of February 14, 2001, Respondent took a flight out of Los Angeles International Airport to attend neurosurgery seminars in Bombay, India and in Colorado. He returned to Los Angeles after 11:00 p.m. on February 19, 2001. The trip had been planned at least several weeks in advance, and a note at the bottom of Respondent's itinerary indicated that "1/25/01 purchased ticket."

82(a). Steve F. was not aware that Respondent was going out of town for medical seminars following his February 8, 2001 surgery, and was not told so.

82(b). Respondent testified that he did not recall discussing his anticipated absence with Steve. F., but that he was "sure" he had done so. Respondent did not explain how he was so "sure" he had done so, without any recollection of the discussion. Additionally, given that Respondent had told Steve F. before the surgery he would walk out of the hospital following the surgery (which he did) and that he could immediately return to leading his normal life, it seems unlikely that Respondent would have felt the need to inform Steve F. of his anticipated absence beginning seven days post-surgery. Consequently, Respondent's unfounded insistence that he had informed Steve F. of his anticipated absence is not persuasive.

83. Susan F., who was very worried about her husband's condition, called Respondent's office twice on February 15, 2001, and eleven times on February 19, 2001, to get help for her husband. She spoke to Respondent's staff member named Trish, who never told her that Respondent was out of town. Susan F. never spoke to Dr. Thomas Clifford during those phone calls.

84. On February 15, 2001, a prescription for Carisoprodol was phoned into the Longs Drugs near Steven F.'s home, and Susan F. picked up that prescription. On February 19, 2001, prescriptions for Cyclobenzaprine, Dexamethasone and Ranitidine were phoned into the Longs Drugs near Steven F.'s home. The Longs Drugs records indicate that the prescribing physician for the Carisoprodol, Cyclobenzaprine, Dexamethasone and Ranitidine was "J. Chiu."

85. On February 19, 2001, during one of Susan F.'s phone calls to Respondent's office, Trish told her the she needed to use "tough love" and that she needed to move Steve F. However, she could not do so, and therefore called an ambulance. On that date, Steve F. was taken by ambulance and admitted to St. Agnes Medical Center in Fresno, California,

with severe lower back pain. He also had a slight temperature elevation. He remained at St. Agnes for 21 days.

86(a). Respondent testified that Dr. Thomas Clifford, a board certified neurosurgeon, and an associate of his, would cover Respondent's patients when Respondent left town. Respondent insisted that, when he was out of town in February of 2001, Dr. Clifford was in charge of covering his patients, including Steven F. He asserted that the doctor left in charge is 100 percent responsible for the patients.

86(b). Respondent's assertion that Dr. Clifford was left in charge of Steven F.'s care from February 15 through February 19, 2001, was not convincing for the following reasons:

(1). The prescriptions for February 15 and 19, 2001 were issued with Respondent listed as the prescribing physician, not Dr. Clifford. Respondent attempted to explain this documentation, stating that, although his staff asked Dr. Clifford for the prescription, they automatically used Respondent's name on the prescription because Respondent was the patient's physician. He noted that Dr. Clifford's name should have been on the prescription and that occurrence was an exception to what usually happens. However, Respondent's explanation is not credible, since the "exception" happened on two occasions. Additionally, if Dr. Clifford had been in charge of Steve F.'s care, and (by Respondent's account) 100 percent responsible for the patient during that time frame, it seems more likely that he would have issued the prescription under his own name. Notably, Dr. Clifford did not provide testimony to clarify this issue.

(2). Contained in Steve F.'s medical records was a progress note, dated February 20, 2001, signed by Dr. Thomas Clifford, indicating:

> Was notified [that Steve F.] was in [the] ER . . . at St. Agnes Med. Center . . . [with] low back pain & muscle spasm. Spoke [with] wife – he had been "unable to move, to get out of bed" for 5 days.

Dr. Clifford's February 20, 2001 progress note appears to indicate that Dr. Clifford was unaware of the patient's inability to get out of bed for five days until he was informed by Steve F.'s wife on February 20, 2001. This does not support Respondent's assertion that Dr. Clifford was in charge of his patient from February 14 through 19, 2001.

(3). During the numerous frantic phone calls made by Susan F. to Respondent's office between February 15 and February 19, 2001, Respondent's staff never informed Susan F. that Dr. Clifford was covering Respondent's patients.

(4). During the numerous phone calls made by Susan F. to Respondent's office between February 15 and February 19, 2001, Dr. Clifford never talked to Susan F.

(5). Respondent never told Steven F. that Dr. Clifford would be covering for him from February 15 through February 19, 2001.

(6). There was no evidence (testimonial or otherwise) that Dr. Clifford ever accepted responsibility to cover Respondent's patients between February 15 through February 19, 2001.

87. On February 21, 2001, Respondent wrote his first post operative follow up note in the Steve F. case, which summarized what had occurred after Steve F.'s surgery.

88. On March 1, 2001, a CT-guided needle biopsy of the patient's L-3 disc space was performed because of a concern of disc space infection. The culture was negative. On March 6, 2001, a biopsy of the L2-3 and L3-4 levels was taken, with negative results. Since there was a prospect of disc space infection, a course of antibiotics was started, after which there was improvement of the patient's symptoms. Steve F. was discharged from St. Agnes Medical Center on March 13, 2001, with a discharge diagosis which included "postoperative lumbar microdiskectomy with presumed infectious spondylodiscitis at L2-3 and possibly L3-4 levels." He was ordered to continue the course of antibiotics at home, which he did. He also began physical therapy on October 1, 2001.

89. On December 7, 2001, Steve F. was readmitted to St. Agnes Medical Center, after a December 5, 2001 MRI showed an abscess and infection at L2-3. Steve F. was discharged on December 13, 2001, and began another course of antibiotics.

The Experts

90(a). Complainant offered the testimony of Willim R. Taylor, M.D. to establish the standard of care. Dr. Taylor obtained his medical degree from University of California Los Angeles in 1987 and is licensed to practice medicine in California. Dr. Taylor completed his residency in neurological surgery at Albert Einstein College of Medicine in New York (1988-1993), and then completed a NY Spine Fellowship at Columbia University in New York (1993-1994). He has been a diplomate of the American Board of Neurological Surgery since 1996. He has held teaching positions at University of California San Diego, Division of Neurological Surgery, as an Assistant Clinical Professor (1994-2000), an Associate Clinical Professor (2000-2007) and a Clinical Professor, his current position. Dr. Taylor currently treats patients and specializes in spine surgery, with an interest in minimally invasive surgery. He is currently involved in six clinical trials focusing on various subjects, including minimally invasive surgery. He has had numerous peer-reviewed articles published pertaining to the field of neurology.

90(b). Respondent offered the testimony of Martin Krell, M.D. to establish the standard of care. Dr. Krell obtained his medical degree from University of Southern California in 1965. He has been licensed to practice medicine in California since 1966 and has been a diplomate of the American Board of Neurological Surgery since 1975. He completed a residency in general surgery at University of California Los Angeles, Wadsworth Veterans' Hospital (1966-1967) and completed a residency in neurosurgery at University of California Irvine, Long Beach Veterans Administration (1967-1972). He has

been a Clinical Assistant Professor of Neurosurgery at USC from 1985 through the present. He has also held several professional appointments, including Chief of Surgery (1984-1985) and Chief of Staff (1986-1987) at Daniel Freeman Marina Hospital, Chairman of the Peer Review Committee, Division of Neurosurgery at Cedars-Sinai Medical Center (1993-1996), and Chief of Neurosurgery (2001-2004) at Century City Hospital.

90(c). Both Dr. Taylor and Dr. Krell were equally qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

90(d). Respondent also offered the testimony of Board-certified orthopedic surgeon Vert Mooney, M.D. to establish the standard of care. Although Dr. Mooney is certified in a different specialty, his testimony focused on the standard of care for spine surgeons, and demonstrated that there is "overlap" in the two specialties (orthopedic surgery and neurosurgery) for certain procedures on the spine. Dr. Mooney's testimony was considered to supplement Dr. Krell's testimony regarding the standard of practice in particular procedures. However, only Dr. Krell's testimony was relied upon to establish the standard of care for neurosurgeons and whether Respondent breached that standard of care.

Standard of Care Re: Treatment of Donna A.

91(a). Dr. Taylor opined that Respondent failed to address Donna A.'s peri-operative problems and complications. He noted that Respondent's only extreme deviations from the standard of care were his failure to treat the patient's hematoma and his failure to secure an airway.

91(b). Dr. Taylor testified that, if blood came out from the inserted surgical needle, and Respondent removed and reinserted the needle, the appropriate response within the standard of care would have been based on the amount of blood at the time. He first stated that it would be below the standard of care for a neurosurgeon to apply pressure for only 30 seconds after seeing the blood. However, he later stated that, if pressure is applied for 30 seconds and "everything is okay," then that is an adequate response. He also testified that applying pressure for five minutes would likely reach the standard of care, but the neurosurgeon would still need to monitor the patient for development of a hematoma. According to Dr. Taylor, if the patient became hoarse, agitated and restless, and Respondent asked Dr. Shahangian to address the hoarseness and agitation with dexamethasone because he believed the symptoms indicated an allergic reaction, Respondent's course of action would have been proper. If the patient continued with the outward signs of hoarseness and restlessness, and the anesthesiologist believed that a hematoma was developing and that a bulge was forming on the right side of the patient's neck at the needle's point of entry, Respondent would have to revisit decision of how to proceed. However, there is no specific time limit for making such a reassessment. According to Dr. Taylor, if the patient is able to talk and breathe, the timing of the reassessment would depend on how patient is doing.

91(c). Dr. Taylor further testified that, once a neurosurgeon discovers the existence of a hematoma in a patient, the situation becomes an "absolute medical emergency." The standard of care requires that an airway be established immediately by intubation or tracheostomy and, at the same time, the surgeon must evacuate the hematoma by incision in the neck.

91(d). Dr. Taylor asserted that the standard of care requires neurosurgeons to be able to establish a surgical airway by tracheostomy, and that this skill is still required for Board certification for neurosurgeons. He also asserted that it would be within the standard of care for neursurgeons to be able to perform a cricothyrotomy. Dr. Taylor noted that a surgical airway was necessary for Donna A.. He opined that Respondent's closing the patient after the attempted tracheostomy was not appropriate, since proper treatment of the hematoma required draining the hematoma with an incision in that area. He admitted that, if Respondent abandoned the tracheostomy because of a 100 percent reading on the pulse oxymeter, he "would have less concern about proceeding with a tracheostomy." However, he noted that the pulse oxymeter is only one of the factors to look at, and that the readings can drop quickly.

91(e). In rendering his opinion that Respondent failed to treat Donna A.'s hematoma, Dr. Taylor assumed that a hematoma formed as a result of Respondent's actions. Dr. Taylor assumed that Respondent inserted the trochar into Donna A.'s neck and saw blood; that 10 minutes later, Donna A. became hoarse, agitated and restless; and that, as stated in the autopsy report, an internal jugular vein tear was the likely cause of a hematoma. However, these assumptions were not borne out by the evidence. (See Factual Findings, above.) Additionally, Dr. Taylor admitted that, if it was established that a hematoma was not causing a problem for the patient, this would change the surgeon's need to address that problem.

91(f). On cross examination, Dr. Taylor agreed that the anesthesiologist is "in charge of the airway" and the surgeon is "in charge of the operation." Dr. Taylor admitted that, assuming that no hematoma existed; that the anesthesiologist decided to convert to general anesthesia; administered propofol and succynolcholine, and made multiple attempts to intubate using laryngoscopes with Miller and Macintosh blades; that the anesthesiologist was unable to see the epiglottis or vocal chords and was unable to place an endotracheal tube; that the anesthesiologist subsequently used an LMA, connected to the anesthesia machine, and manually tried to pump air in; that the anesthesiologist asked Respondent to perform a tracheosotomy leading to a tracheotomy to establish a surgical airway; and that Respondent made the incision, but was unable to complete the tracheostomy, Respondent did not commit a major deviation from the standard of care. Dr. Taylor also admitted that, assuming Respondent nicked the internal jugular vein and caused some bleeding from the low pressure vessel which did not form a discrete hematoma; that the tissues and muscles surrounding the internal jugular vein were intact except at the place of puncture; that there was no tracheomalacia, distortion or deviation of the trachea; that the patient was agitated, complaining and talking to a nurse; that Respondent requested additional conscious sedation, not general anesthesia; but that the anesthesiologist decided to convert to general anesthesia and went through the process stated above, Respondent committed no major deviation from

the standard of care. Dr. Taylor noted the fact that Respondent did not participate in the decision to convert to general anesthesia makes a difference in his analysis, because "you are changing over your roles and changing the course of procedure, since you are now talking about securing an airway." Dr. Taylor opined that, if the anesthesiologist converted to general anesthesia without instruction from Respondent, it made Respondent's "job more difficult," since he had to deal with a patient who had just been paralyzed, sedated and could not be intubated. Dr. Taylor stated that this was a "difficult position to put a surgeon in," and that he was unable to opine, within a reasonable degree of medical certainty, that Respondent engaged in a major deviation from the standard of care under those circumstances.

92(a). Dr. Krell testified that, assuming the anesthesiologist decides to convert to general anesthesia and administers propofol and succynolcholine; that the anesthesiologist cannot visualize the epiglottis and vocal chords and is unsuccessful in intubating the patient; that the patient is not breathing because she is paralyzed from succynolcholine; and that a neurosurgeon is asked to attempt tracheostomy leading to tracheotomy, it is not below the standard of care for the neurosurgeon to be unable to complete the tracheostomy. According to Dr. Krell, the neurosurgeon may not know how to perform a tracheostomy or may not have performed such a procedure for an extended amount of time. Dr. Krell also noted that the patient may have an anatomy which makes a tracheostomy difficult, such as a short neck or being-overweight with fat on the neck and chest, which makes the approach to the trachea difficult.

92(b). Dr. Krell testified that the history and physical that Respondent performed on Donna A. on November 25, 2002, constituted a full neurological examination of the patient. The ensuing report set forth the patient's history of problems and treatment, a review of her symptoms, documentation of a physical examination which included a neurological examination to determine the patient's current manifestations, a review of radiological studies and recommendations which included a discussion of the risks and alternatives of the proposed procedures. Dr. Krell opined that the standard of care does not require the neurosurgeon to specifically state the levels of the cervical spine on which he is going to operate. According to Dr. Krell, a neurosurgeon could be looking at multiple levels in a procedure and may discover that a level not previously suspected is causing pain. In that instance, it is not feasible to wake the patient to obtain consent to operate on that additional level.

93. Dr. Mooney confirmed that Respondent's November 25, 2002 preoperative evaluation met the standard of care for spine surgeons. He noted that, in the recommendations section of the report, it is not necessary for a surgeon to lay out every risk and element that was discussed with the patient.

94. With regard to the Donna A. case, based on the facts established by the evidence and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent committed any deviations from the standard of care.

Standard of Care Re: Treatment of John C.

95. Dr. Taylor testified that Respondent committed only minor deviations/ simple departures from the standard of care in his treatment of John C.

96. Dr. Taylor opined that, based on the operative report, there is no evidence of intra-operative discussions with the patient, nor any documentation of his level of consciousness. This was below the standard of care. Dr. Taylor found it significant that the operative report was almost identical to the operative report in Steve F.'s case, so that in both cases there were three levels of positive discography and then three levels of discectomy.[19]

97. Dr. Taylor opined that Respondent's record keeping fell below the standard of care because there was no evidence of documentation in the post-operative chart concerning the patient's post operative visit. This opinion was unchanged even after the progress notes from the patient's post-operative visits were forwarded to the Board and then to Dr. Taylor. As indicated above in Factual Finding 65, Complainant did not prove that "Respondent failed to document the patient's post operative visits on August 29, 2002 and September 17, 2002."

98(a). Dr. Taylor noted that John C. had a post operative complication of a recurrent disc herniation at the L4-5 level, along with right-side leg pain and weakness. According to Dr. Taylor, Respondent needed to continue to seek the cause of the new right-sided neurological finding after surgery. Respondent did not identify any right foot drop in his post operative notes. However, relying on the records of John C.'s subsequent treating physicians, Dr. Taylor noted that, on October 1, 2002, Dr. Fogal identified a right foot drop and right side weakness. Additionally, an MRI conducted on October 3, 2002, revealed a herniated disc at L4-5 toward the right side and spondylolysthesis. According to Dr. Taylor, the herniation could cause right side radicular leg pain.

98(b). Dr. Taylor noted the administration of SI joint trigger point injections and prescription of Neurontin is an adequate response to post operative pain. However, this prescription must be coupled with an investigation into why a patient has new post operative symptoms. Dr. Taylor opined that, in John C.'s case, SI joint trigger point injections were not an adequate response. Given the preoperative spondylolysthesis and normal neurological examination, a post –operative foot drop and severe right-sided radicular pain should have been evaluated with an MRI scan, unless a clear indication of its cause was found. While an EMG and CT scan are typically ordered, these are not as helpful as an MRI. In John C.'s

[19] This duplication in language is not sufficient to contradict Respondent's assertion that he had intra-operative discussions with the patient. Respondent may have failed to document specifically what the patient said when the discography produced "positive reproduction of pain." However, the Second Amended Accusations alleges only that "Respondent failed to have any discussions with John C. during the August 16, 2002 procedures," not that he failed to document the specifics of those discussions. As set forth in Factual Finding 57, the evidence established that Respondent had intra-operative discussions with the patient and that the patient responded verbally regarding the pain he felt.

case, the EMG revealed radiculopathy at L-5, and the CT scan did not reveal the cause of the new symptoms. An MRI was needed to evaluate for herniated discs. Dr. Taylor opined that Respondent's failure to seek a reason for the new neurological deficit after an EMG revealed L-5 radiculopathy fell below the standard of care for neurologists.

99. Dr. Krell opined that Respondent's August 15, 2002 history and physical report met the standard of care for board certified neurologists. Although the report noted a discussion of risks without listing all of them specifically, if Respondent discussed them all as he testified, the report meets the standard of care.

100. Dr. Krell testified that, in the operative report, the phrase "positive reproduction of preoperative pain and abnormal discogram of L3, L4 and L5 noted," implied that, in order to obtain that information, the patient was sufficiently conscious to be able to relate his symptoms to Respondent during the discogram. The phrase also implied that some communication took place between the patient and Respondent. Consequently, Dr. Krell opined that the operative report met the standard of care for neurologists.

101(a). Dr. Krell noted that post-surgically, John C. was complaining of pain in a non-surgery area. However, he noted that the SLR test was "slightly abnormal, almost normal." According to Dr. Krell, the September 17, 2002 progress note does not document any significant injury or problem. He opined that Respondent's examination represented a reasonable examination of the patient's complaint. He further opined that Respondent's ordering an EMG was appropriate since the patient was complaining of weakness in his foot, "a dropped foot," and an EMG could determine if a nerve was injured. However, Dr. Krell insisted that, at the time, the patient was not suffering from a "full-on foot drop." He noted that it is often "hard to interpret" based on cooperation of the patient or "breakaway weakness from pain." He also noted that Dr. Kissel's later examination did not indicate a "clear cut foot drop," but only mild weakness.

101(b). Dr. Krell opined, assuming that the patient was about 80 years old and intolerant and that, on September 17, 2002, Respondent chose to order a CT scan over an MRI because the CT scan took only a couple of minutes and the MRI took 30 to 40 minutes, requiring patience and confinement, Respondent's ordering of the CT scan was within the standard of care.[20] Dr. Krell stated that an MRI "picks up water," so if a physician orders an MRI within a few months after surgery, he/she may see water signals intermingled with inflammation, and it is very hard to interpret and may give a false positive. Therefore, a CT scan within the first three months of an operation is within the standard of care, and is in fact the standard of care. Dr. Krell opined that Respondent did not fall below the standard of care in his post operative care of John C.

[20] As indicated in Factual Finding 64, the patient's intolerance was belied by the fact that he underwent MRIs prior and subsequent to September 17, 2002.

102. Dr. Mooney testified that the Neurontin and SI joint injections adequately addressed the patient's complaints until Respondent obtained the information from the CT scan. Dr. Mooney stated that, after Respondent had the appropriate information from the CT scan, he should have started to consider other mechanics to address the post operative complaints. However, Dr. Mooney opined that Respondent should not order an MRI unless it is necessary (i.e. the CT scan does not tell him enough). He noted that a CT scan is an appropriate method of assessing reherniation of discs, just like an MRI.

103. Based on Factual Findings 49, 51 and 56, and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent deviated from the standard of care in his pre-operative evaluation discussing the risks and benefits of the procedures performed.

104(a). Based on Factual Findings 49, 51, 52, 54, 55 and 57, and the collective opinions of Drs. Taylor and Krell, it was not established that Respondent deviated from the standard of care during the August 16, 2002 procedure because it was not proven that he "failed to have any [intra-operative] discussions with John C."

104(b). With regard to Respondent's failure to document John C.'s level of consciousness in the operative report, the opinions of Dr. Taylor, set forth at Factual Finding 96, were more persuasive than those of Dr. Krell, and are adopted as facts herein.

105. Based on Factual Findings 59, 61 and 65, and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent departed from the standard of care in his documentation of post operative visits, since it was not proven that Respondent "failed to document [John C.'s] post operative visits on August 29, 2002, and September 17, 2002."

106. With regard to John C.'s post operative complaints, the testimony of Dr. Taylor was more persuasive than that of Drs. Krell and Mooney. Therefore, the opinions of Dr. Taylor, set forth in Factual Finding 98, are adopted as facts herein. As indicated by Dr. Krell's testimony, the patient was complaining of weakness in his right foot, although Respondent did not identify this as a problem or interpret it as a "dropped foot." Given the weakness and radiculopathy, the standard of care required Respondent to seek to determine the reason for any new neurological deficit by way of an MRI.

Standard of Care Re: Treatment of Steve F.

107(a). Dr. Taylor testified that, following lumbar discograms and endoscopic discectomies, due to the insertion of instruments into the disc space, the patient can develop the post operative complication of discitis, an inflammation of the disc space, which often involves a bacterial infection in that location. The patient suffering from discitis typically has recurrence of radiculopathy and debilitating, severe lower back pain. Discitis takes a long time to treat, and the standard of care for the treatment of discitis is the use of

antibiotics. Usually a biopsy is conducted to tailor the antibiotics, but often the biopsy is negative because no bacteria can be cultured out of the disc area.

107(b). Dr. Taylor opined that Respondent's post operative care of Steve F. fell below the standard of care for post operative treatment. Based on the patient's lower back pain, severe recurrence of symptoms, blood test results and low grade fever with an MRI consistent with discitis at L2-3, Dr. Taylor opined that Respondent failed to recognize that Steve F. had developed the post operative complication of infection. None of the medications prescribed by Respondent addressed the patient's infection. Instead, the medications prescribed were an anti-inflammatory medication (e.g. Dexamethasone), a medication for stomach upset (e.g. Ranitidine) and muscle relaxants, prescribed for acute radiculopathy or muscle pain after surgery. Although discitis symptoms must be dealt with quickly, Dr. Taylor noted that the patient did not receive appropriate treatment for his infection until he went to St. Agnes Medical Center. Therefore, Respondent did not timely respond to Steve F.'s infection. Dr. Taylor acknowledged that, although a neurosurgeon need not assume immediately that an infection is present, he/she must consider the severity of the illness. Infectious discitis is debilitating and very severe, and in this case, the patient was experiencing debilitating pain, along with fever and testing that indicated infection. Taylor found it significant that the patient called Respondent's office so many times. According to Dr. Taylor, Respondent's failure to respond to the patient's numerous calls falls below the standard of care for treatment in a post-operative setting. Dr. Taylor noted that, if Respondent had responded to the patient's calls, it should have been easy for Respondent to identify that the patient was suffering from discitis and would have been able to care for him. Dr. Taylor opined that Respondent's deviation from the standard of care in Steve F.'s post operative treatment was a major departure from the standard of care and equivalent to gross negligence.

107(c). Dr. Taylor further opined that it is a deviation from the standard of care if a patient is left with no competent physician in charge of taking care of this problem. He emphasized that a family doctor or primary care physician is not capable of addressing the post-operative complications of infection, and that it is incumbent on the neurosurgeon to follow up or to arrange follow up by a competent neurosurgeon, if he/she is unable to personally follow up with the patient. Dr. Taylor admitted that, if Respondent had left a Board-certified neurosurgeon, with whom Respondent had a history in practice, in charge of his patients when he left town, that would make a significant difference in his opinion. However, as set forth in Factual Finding 86, it was not established that Dr. Clifford had been responsible for Respondent's patients, including Steven F., when Respondent was out of town from February 15 through 19, 2001.

108(a). With regard to Respondent's preoperative evaluation report for Steve F., Dr. Taylor testified that, assuming Respondent discussed with Steve F. that infection could be a complication of his surgery, the document was sufficient to convey that the patient had been so advised. However, as set forth in Factual Findings 70 and 71, despite Respondent's documentation of such a discussion, Steve F. was not informed that infection was one of the risks or complications associated with a provocative lumbar discogram and endoscopic

discetomy. Dr. Taylor did not testify that the failure to have this discussion, in itself, was a violation of the standard of care. However, it can be assumed that, if documentation of the discussion is required by the standard of care, then the conversation itself must be required as well. Additionally, given that Dr. Taylor found the document sufficient only if Respondent actually discussed the complications of surgery, the actual conversation appears to be the key component of Dr. Taylor's analysis, with the documentation used only to confirm compliance with the standard of care.

108(b). Moreoever, although Dr. Taylor did not so testify specifically, the documentation of a conversation that did not take place constitutes a failure to keep accurate records. This lack of accuracy is easily apparent to a lay person and does not need to be established by expert opinion.

109. Dr. Taylor opined that, based on the operative report, there is no evidence of intra-operative discussions with the patient, nor any documentation of his level of consciousness. As with John C., this was below the standard of care. Steve F.'s operative report and records revealed that a provocative discogram was done, concurrent with an EMG. The neurosurgeon needs to tailor post-discogram treatment to what the patient tells the surgeon at the time of the discogram. Based on the operative report, Respondent apparently proceeded to a three-level discectomy based solely on an intra-operative, three-level provocative discogram, without reliance on patient input. There was no indication as to whether Steve F.'s leg pain had been caused by L2-3, L3-4 or L4-5. Dr. Taylor opined that there was no indication in the operative report that Respondent obtained any patient response or that the provocative discogram had any effect on which procedures were subsequently performed.

110. When asked if Respondent should have documented all of the post operative phone calls made to his office, Dr. Taylor testified that "it is a matter of degree." If a patient makes one or two calls and is unable to get a hold of someone, those calls need not be documented. However, "a continual inability needs to be documented." This testimony was insufficient to establish that the standard of care required that Respondent document all post-operative checks and that Respondent "failed to document the patient's post-operative checks and numerous telephone calls, and thereby departed from the standard of care."

111. Dr. Krell testified that, when Steve F. called Respondent's office complaining of pain in the disc area operated on, two days after his percutaneous lumbar discectomy, and Respondent prescribed dexamethasone, Vicodin and Zantac, this met the standard of care for addressing initial complaints of pain following discectomy. Dr. Krell acknowledged that the medications prescribed for Steve F. did not address infection. However, he pointed out that a neurosurgeon with a patient complaining of post-operative pain need not immediately consider infection within the first few days post-surgery. He testified that he did not think that, at that time, Steve F. had discitis, but was merely complaining of pain. Nevertheless, Dr. Krell admitted that, it is reasonable that, with increasing pain, infection should be considered.

112. Dr. Krell testified that, assuming that a patient has a primary care physician and that there was some contact between that physician and the patient on an ongoing basis, it is reasonable to expect the neurosurgeon's out-of-town patient to see his own primary care physician during the post operative period.

113. Dr. Krell testified that, assuming Respondent left the country and arranged for Dr. Clifford, a board-certified neurosurgeon, to provide coverage for his patients, it would have been Dr. Clifford's responsibility to cover the patients. Dr. Krell also testified that, assuming Steve and Susan F. made numerous phone calls while Dr. Clifford was covering Respondent's patients, it would have been Dr. Clifford's responsibility to answer those calls. According to Dr. Krell, if the neurosurgeon has a physician's assistant cover his patients, then the patients would remain the responsibility of the neurosurgeon. However, if the neurosurgeon's colleague with the same qualifications covered his patients, then the patients are the colleague's responsibility. However, as set forth in Factual Finding 86, it was not established that Dr. Clifford was covering Respondent's patients, including Steven F., when Respondent was out of town from February 15 through 19, 2001.

114. Dr. Krell testified that Respondent's pre-operative evaluation of Steve F. was adequate, and that Respondent met the standard of care regarding discussion with the patient of the risks and benefits of the proposed procedures. However, Dr. Krell's opinion was based on the assumption that Respondent actually had a discussion with the patient regarding the risks of the proposed procedures. This assumption was not borne out by the evidence. As set forth in Factual Findings 70 and 71, despite Respondent's documentation of such a discussion, Steve F. was not informed of all of the risks, complications and alternatives associated with a provocative lumbar discogram and endoscopic discectomy.

115. Dr. Krell also opined that the history and physical report met the standard of care for neursurgeons in Southern California in 2001. However, as addressed in Factual Finding 108, the documentation of a conversation that did not take place does not meet the standard of care.

116. Dr. Krell testified that the operative report met the standard of care regarding the documentation of the patient's level of consciousness. As a board-certified neurosurgeon reading the operative report, Dr. Krell could ascertain the level of consciousness of Steve. F. during the provocative discogram because the report indicated that the patient was able to respond to the injection of the dye into the discs. Dr. Krell stated that he could tell from the report that the patient could appreciate pain because the patient could express the sensation of "positive reproduction of preoperative pain." Dr. Krell testified that the documentation of "positive reproduction of preoperative pain" is adequate documentation of discussions with the patient regarding the goal of the provocative discogram.

117. Except for the testimony noted in Factual Finding 110, the testimony of Dr. Taylor was more persuasive than that of Dr. Krell. Therefore, the opinions of Dr. Taylor, set forth in Factual Findings 107 through 109, are adopted as facts herein.

Alleged Bases for Discipline

118. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 13 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by a failure to "perform and document a preoperative assessment of Donna A.,"

119. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 14 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by a failure to "address peri-operative problem and complications" or by a "decision to allow the induction of general anesthesia in response to Donna A.'s coughing and becoming hoarse, agitated and restless and her developing a hematoma."

120. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 15 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by "inducing general anesthesia on Donna A., rather than stopping the diskogram procedure when she began to suffer complications."

121. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 16 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by failing to place "a large bore needle into the [patient's] trachea and/or perform an exploration of the anterior cervical triangle to evacuate the blood clot prior to performing the tracheotomy;" by failing to "capably perform the operative procedures that can arise with the risks associated with a cervical discogram;" or by failing "to establish a surgical airway for Donna A."

122. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 13, 14, 15, 16, and 18, because it was not established that Respondent committed repeated acts of negligence in his care and treatment of Donna A.

123(a). Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 26 and 28, that Respondent committed repeated acts of negligence in his care and treatment of John C. by his failure to document John C.'s level of consciousness and his failure "to perform an MRI on John C. to assess his complaints of severe right-sided radicular pain and right footdrop."

123(b). Complainant did not establish, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 25 and 27.

124. Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 39, that Respondent committed gross negligence in his care and treatment of Steve F. by failure "to personally follow-up with

Steve F. regarding his post-operative status," by failure to "refer Steve F to a physician in his area to assess his post-operative status during the period of February 12 to 19, 2001," by failure to "identify that Steve F. may have been suffering from an infection, despite his thirteen [plus] telephone calls from February 12, 2001 to February 19, 2001 to his office complaining of lower back pain."

125(a). Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 41 and 42, that Respondent committed repeated acts of negligence in his care and treatment of Steve F. by failing to "fully perform . . . a pre-operative evaluation discussing the risks and benefits of proposed procedures with the patient," and by failing to document intra-operative discussions with the patient."

125(b). Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 43, because it was not established that Respondent departed from the standard of care by failing to document the patient's post-operative checks and phone calls.

126. Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 44, that Respondent failed to maintain adequate and accurate records relating to the provision of services to John C. (failure to document level of consciousness) and to Steve F. (failure to document intra-operative discussion and level of consciousness; and documentation of a conversation that did not occur).

Prior Discipline

127. In a Decision effective August 16, 2002, the Board issued a public letter of reprimand to Respondent.[21]

LEGAL CONCLUSIONS

First Cause for Discipline – Gross Negligence / Patient Donna A.

1. Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish that Respondent was grossly negligent in his care and treatment of patient Donna A., as set forth in Factual Findings 3 through 48, 91 through 94, 118, 119, 120 and 121.

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[21] Although the Second Amended Accusation alleged the bases for the issuance of the public letter of reprimand, these bases were not established by the evidence.

Second Cause for Discipline – Repeated Negligent Acts / Patient Donna A.

2. Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish that Respondent committed repeated acts of negligence in his care and treatment of patient Donna A., as set forth in Factual Findings 3 through 48, 91 through 94, 118, 119, 120, 121 and 122.

Third Cause for Discipline – Repeated Negligent Acts / Patient John C.

3(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds that Respondent committed repeated acts of negligence in his care and treatment of patient John C. (failure to document level of consciousness and failure to perform MRI) as set forth in Factual Findings 49 through 65, 95 through 106, and 123.

3(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds of repeated acts of negligence for failure to perform and document a preoperative evaluation and for failure to document post operative visits, in that Complainant failed to establish that Respondent committed these repeated acts of negligence in his care and treatment of patient John C., as set forth in Factual Findings 49 through 65, 95 through 106, and 123.

Fourth Cause for Discipline – Gross Negligence / Patient Steve F.

4. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Respondent was grossly negligent in his care and treatment of patient Steve F., as set forth in Factual Findings 66 through 89, 107 through 109, 117 and 124.

Fifth Cause for Discipline – Repeated Negligence Acts / Patient Steve F.

5(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds that Respondent committed repeated acts of negligence in his care and treatment of patient Steve F. (failure to fully perform preoperative evaluation and failure to document level of consciousness and intra-operative discussions with patient), as set forth in Factual Findings 66 through 89, 107 through 109, 117 and 125.

5(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds of repeated acts of negligence for failure to document post operative checks and phone calls, in that Complainant failed to establish that Respondent committed

this act of negligence in his care and treatment of patient John C., as set forth in Factual Findings 66 through 89, 110, 117, and 125.

Sixth Cause for Discipline – Failure to Maintain Adequate and Accurate Records

6. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, on the grounds that Respondent failed to maintain adequate records relating to patients John C. (failure to document level of consciousness) and Steve F. (failure to document intra-operative discussion and level of consciousness; and documentation of a conversation that did not occur), as set forth in Factual Findings 45 through 89, 95 through 106 through 109, 117, and 126.

Analysis re: Level of Discipline

7(a). Complainant established that Respondent committed gross negligence with one patient, repeated negligent acts with two patients and failed to maintain adequate and accurate records for two patients. The gross negligence was based on Respondent's absence rather than a lack of skill, and the repeated acts of simple negligence were based on failure to conduct an informed consent discussion, failure to perform an MRI (which is not a record keeping violation) and various documentation violations. The remaining question is the nature of the discipline to be imposed against Respondent's certificate, and that question can be answered by the imposition of a probationary period with the appropriate terms and conditions to protect the public and to aid in Respondent's rehabilitation.

7(b). Business and Professions Code section 2229, provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, [or] the division, . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . .

7(c). Business and Professions Code section 2227, subdivision (a), provides:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

(4) Be publicly reprimanded by the division.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

7(d). In determining the level of discipline, it is noted that Respondent has been disciplined previously, although (according to the Accusation) the prior discipline was not based on grounds similar to the current violations. While Respondent did not admit any violations at the hearing, this does not necessarily presage an unwillingness to undertake any rehabilitation ordered by Board. In light of the nature of his violations, a properly-conditioned probationary period that includes a clinical training program and a record keeping course will protect the public without imposing overly harsh and punitive discipline on Respondent.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Physician's and Surgeon's Certificate No C31784, issued to Respondent John C. Chiu, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for three (3) years upon the following terms and conditions.

1. Notification

Prior to engaging in the practice of medicine, Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

6. Interview with the Board or Its Designee

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

7. Residing or Practicing Out-of-State

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar

days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and, for any reason, Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the

disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee, and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action.

If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall annually provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

13. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

14. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding. Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion. Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

15. Solo Practice

Respondent is prohibited from engaging in the solo practice of medicine.

16. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, Respondent's certificate shall be fully restored.

This Decision shall become effective at 5:00 p.m. on July 21, 2008

IT IS SO ORDERED THIS 20th day of June, 2008.

Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOHN C. CHIU, M.D.** Physician's & Surgeon's Certificate No.: C31784 Respondent	Case No.: 17-2002-141331 OAH No.: L2006010232

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** The Medical Board of California will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit, including in particular, argument directed to the question of whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Kennedy Court Reporters, Inc., 523 W. Sixth Street, Suite 1228, Los Angeles, CA 90014, telephone (800) 231-2682, fax (714) 835-0641.

To order a copy of the exhibits, please contact the Transcript Clerk at the Office of Administrative Hearings, 320 West Fourth Street, 6th Floor, Suite 630, Los Angeles, CA 90013, telephone (213) 576-7200, fax (213) 576-7244.

In addition to written argument, oral argument will be scheduled if any party files with the Board within 20 days from the date of this notice a written request for oral argument. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2639

Dated: January 29, 2008

Cesar A. Aristeiguieta, M.D., F.A.C.E.P.
Chair
Panel A

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 17-2002-141331
JOHN C. CHIU, M.D.,	OAH No. L2006010232
Physician and Surgeon's Certificate No. C31784	
Respondent.	

PROPOSED DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on September 10, 11, 12, 17, 18, 20, 24, 25, 26, 27 and 28, and October 1 and 2, 2007, in Los Angeles, California. Complainant was represented by Gloria Castro, Deputy Attorney General. John C. Chiu, M.D. (Respondent) was present and was represented by William H. Ginsburg of Peterson & Bradford, LLP, with his assistant Sherry Gregorio.

At the hearing, the Second Amended Accusation was amended as follows:

At page 5, line 20, the word "Respondent" was changed to "Dr. Shanhangian," and "he" was changed to "Dr. Chiu."

At page 6, paragraph 12, line 9, the word "and" was deleted, and the sentence stating, "A tracheostomy was performed on Donna A. by another physician," was moved to line 10, after the sentence stating, "The patient developed bradycardia and suffered a cardiac arrest at 10:35 a.m."

Oral and documentary evidence was received and argument was heard. The record was left open to allow the parties to file simultaneous closing briefs by the close of business on October 12, 2007. Complainant's Written Closing Argument and Respondent's Supplemental Brief Regarding Closing Argument were timely filed, marked as Complainant's Exhibit 47 and Respondent's Exhibit AA, respectively, and lodged. The record was closed and the matter was submitted for decision on October 15, 2007.

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FACTUAL FINDINGS

1. On December 15, 2005, the Accusation was filed. Respondent's Notice of Defense was filed on January 26, 2006. On June 22, 2007, Complainant, David T. Thornton, filed the Second Amended Accusation while acting in his official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On November 4, 1969, the Board issued Physician and Surgeon's Certificate Number C31784 to Respondent. Respondent's Certificate was in full force and effect at all relevant times and was scheduled to expire on August 31, 2007, unless renewed. The evidence did not disclose whether the license has been renewed. However, if the license was not renewed, the Board retains jurisdiction over this matter pursuant to Business and Professions Code section 118, subdivision (b).

Facts Re: Respondent's Treatment of Patient Donna A.[1]

3. On November 11, 2002, Donna A., a 44-year old female, was first examined by Respondent at his facility, the California Center for Minimally Invasive Spine Surgery (CCMISS). Her chief complaints were intractable, increasing neck and upper extremity pain, the left side greater than the right, left shoulder pain, headaches, middle back pain, increasing lower back and leg pain, the right leg greater than the left, with associated numbness and tingling of the right leg, foot and toes.

4. On November 11, 2002, Donna A. filled out an extensive neurological questionnaire regarding the history of her symptoms which followed a 1999 automobile accident and the ensuing treatment by several physicians. Respondent noted that the patient was taking various medications, including Effexor, Ultram, Oxycontin (discontinued the week prior), Darvon, Trazodone, and Klonopin. Respondent conducted a neurological examination of Donna A. Following that examination, Respondent diagnosed the patient with: "Herniated cervical disc with cervical radiculopathy, herniated lumbar disc with lumbar radiculopathy and high thoracic strain/disc disease." Respondent recommended magnetic resonance imaging (MRI) of the patient's cervical spine and lumbar spine for further evaluation, x-rays, and electromyography (EMG) of her right lower extremity for further assessment.

5. On November 11, radiologist Robert A. Princenthal, M.D., took x-rays of Donna A.'s cervical and thoracic spine and MRIs of her cervical and lumbar spine.

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[1] Throughout this decision, patients' initials will be used in lieu of their surnames to protect their privacy.

6. In a November 11, 2002 consultation report, under the section entitled "Recommendations," Respondent noted:

> [D]iscussed with the patient at length regarding her intractable cervical and lumbar disc symptoms, physical findings, MRI scan/EMG findings, and further alternatives of treatment and procedures of provocative cervical and lumbar discogram and microdecompressive endoscopic cervical and lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications including local anesthesia and possible conversion to general anesthesia, with possible risks and complications. She wished to go ahead with the procedures as soon as possible because of her intractable spinal disc symptoms.

7. On November 25, 2002, a medical evaluation was conducted by Dr. Duc Nguyen, M.D. to obtain pre-operative clearance for the proposed procedures on Donna A. Dr. Nguyen's November 25, 2002 report indicated that Donna A.was five feet, four inches tall, weighing 183 pounds, with a past medical history of fibromyalgia, allergic rhinitis, insomnia and depression. Dr. Nguyen cleared the patient for surgery.

8. According to a report dated November 25, 2002, Respondent conducted a further history and physical examination of Donna A. on that date. The findings in this report, signed on November 29, 2002, mirrored the majority of the findings in the November 11, 2002 examination report. Additionally, the Recommendations contained identical language to that in the November 11, 2002 report (set forth in Factual Finding 6, above). However, the November 25, 2002 report also noted that the MRI scan on November 11, 2002, revealed a three millimeter disc protrusion at C4-5 and a two millimeter "slight bulge" at C6-7. The November 25, 2007 report further noted a physical examination, in addition to the neurological examination, with the following findings:

> Blood pressure 120/80, pulse rate 84, respiration 18. She was somewhat nervous. She is mildly obese.
>
> Head, ears, eyes, nose and throat are unremarkable. Neck, slight web neck. Chest was clear. Breasts, soft without mass. Heart, normal sinus rhythm without murmur or cardiomegaly. Abdomen, mild protuberance without organomegaly. Back, please see below. Genitalia, female. Pelvic and rectal examination, per Dr. Nguyen. Extremities were intact.

9. Donna A. was admitted to Alta Monrovia Hospital on November 26, 2002, for a provocative discogram and microdecompressive endoscopic cervical discectomy with laser. The procedures were to be performed under monitored anesthesia care (MAC) by anesthesiologist Shariar Shahangian, M.D.

10. A discogram is used to determine if injury to a particular vertebral disc is the source of a patient's pain. During a discogram, a surgical needle is inserted into a disc at the level which the physician suspects may be causing the patient's symptoms. Contrast dye is injected into the disc, and the extra fluid in the disc increases the pressure in the disc. A provocative discogram is not done under general anesthesia. It requires that the patient be awake and sedated, so that, upon insertion of the surgical needle into the disc space, the patient can confirm experiencing pain that mimics his/her pre-operative pain. Once the patient confirms replication of the pre-operative pain at a particular level, the physician can proceed with treatment, including an operation on that disc (in Donna A.'s case, by way of microdecompressive endoscopic cervical discectomy with a laser).

11. On November 26, 2002, Donna A. was moved into the operating room (OR) at approximately 9:00 a.m.[2] Dr. Shahangian gave Donna A. Versed (for relaxation) and Fentanyl (for pain tolerance), and then began administering the medication for conscious sedation.

12. At approximately 9:25 a.m., Respondent inserted a 22 to 25 gauge subcutaneous needle into Donna A.'s neck to administer local anesthesia.

13. Thereafter, at approximately 9:25 to 9:30 a.m., Respondent began to insert an 18 gauge surgical needle into Donna A.'s neck, intending to start the discogram.

14. Complainant and Respondent offered differing versions of the events that transpired from the time Respondent attempted insertion of the 18 gauge needle until Donna A. died at 11:39 a.m.

15(a). Dr. Shahangian testified that, at about 9:25 to 9:30 a.m., after Respondent had inserted the surgical needle (which Dr. Shahangian called a "trochar") into Donna A.'s neck, Dr. Shahangian observed blood coming out of the distal end in a "jetting manner indicative of [the needle] entering a major vessel." According to Dr. Shahangian, the blood was "pulsating," and he believed Respondent could have hit an artery or large vein. It was his understanding at the time of the procedure that the blood could have come from the carotid artery. However, at the administrative hearing he testified that, while the internal jugular vein is typically considered a "low pressure" vessel, it is "high pressure" compared to other veins and could "pulsate if there is some resistance to it." Dr. Shahangian stated that, after the blood pulsed out of the needle, Respondent removed the "trochar," put a sponge on the skin at the site of the needle entry and held it for about five seconds before reinserting the needle in a different location. According to Dr. Shahangian, the external bleeding stopped prior to reinsertion of the needle. At this point, the patient tolerated the reinsertion of the

[2] The anesthesia record was not created by Dr. Shahangian in the OR during the procedure, but was constructed several hours later, after the patient had died. Therefore, according to Dr. Shahangian, there are "some mistakes in the times" listed in the record. Consequently, the times set forth in this decision are only approximations.

needle and did not show any outward signs of distress, and Respondent continued his attempt to get into the cervical space. However, Dr. Shahangian noted that, within 10 to 15 minutes after the time of Respondent's reinsertion of the needle, the patient became hoarse, restless and agitated. At that time, Dr. Shahangian observed the patient's neck and did not discern any enlargement or obvious hematoma formation.[3] Nevertheless, according to Dr. Shahangian, he asked Respondent if a hematoma could be the cause of the patient's hoarseness and agitation, and Respondent purportedly stated that there was no hematoma, but that she may be experiencing an allergic reaction. Although he did not record it in the anesthesia record, Dr. Shahangian recalled that, at some point, the IV connector for administration of the conscious sedation medication became dislodged from the patient when she was thrashing around. At about 9:35 a.m. or 9:40 a.m., Dr. Shahangian administered Dexamethasone (to treat possible allergic reaction), without any effect. Dr. Shahangian did not indicate, nor did he document in his anesthesia record, what Respondent was doing during the 10 to 15 minutes after reinsertion of the needle.

15(b). Respondent testified that, in conducting a cervical discogram, he uses his right hand to insert the surgical needle after he uses his left hand to palpate the sternocleidomastoid muscle, pull back the carotid sheath (containing the cartotid artery and internal jugular vein) and apply digital pressure toward the vertebral body. According to Respondent, this creates a "valley" or a "space with no tissue," which is "almost avascular," in order to prevent injury to any blood vessel. Respondent testified that he could not conduct the provocative discogram on Donna A. because, as he began to insert the surgical needle, approximately two to four millimeters into the tissue, the patient began coughing and became restless and agitated. She also complained of pain from the needle insertion. Because she was moving, he removed the needle. He denied seeing "any significant blood" when he withdrew the needle. At some point after removal of surgical needle, Respondent recalled the patient talking to the nurses in the OR and that she sounded "squeaky." Thereafter, he heard from the nurse that the patient's IV line had been disconnected. Respondent stated that performance of the proposed discogram would have taken less than a minute using fluoroscopy.[4] However, the discogram was not performed because the needle "never got to the disc."

15(c). Complainant did not establish, by clear and convincing evidence, that blood was "flushing" or "pulsing out" of the distal end of the 18 gauge surgical needle upon insertion into Donna A.'s neck for the following reasons:

(1) An Accusation was filed by Complainant against Dr. Shahangian on April 20, 2004, and the matter was resolved by Stipulated Settlement and Disciplinary Order,

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[3] A hematoma is a localized, clotted or partially clotted collection of blood situated in tissue outside a vascular structure, usually caused by a break in the wall of a blood vessel.

[4] Fluoroscopy is an imaging technique to obtain real-time images of the internal structures of a patient.

effective April 10, 2006.[5] Following the patient's death, and through the Board's investigation of the incident and prosecution of both Dr. Shahangian and Respondent, each had an equal motive to recall the events that transpired in his favor. Therefore, Dr. Shahangian had a motive to testify in a manner consistent with his prior statements which reflected more favorably on his actions.

(2) There was no other evidence that the blood had been "flushing" or "pulsing" out of the distal end of the surgical needle upon insertion.

(3) As further set forth in Factual Findings 10, 15, 16, 20 and 27, some portions of Dr. Shahangian's are not borne out by the remainder of the evidence. Additionally, the time frame posited by Dr. Shahangian includes 10 to 15 minutes that are not accounted for. According to Dr. Shahangian, it took about 10 to 15 minutes for the patient to become hoarse and restless, which are possible indications of the formation of a hematoma.[6] However, there is no evidence regarding what took place during the 10 to 15 minutes which purportedly lapsed from reinsertion of the surgical needle until the beginning of the patient's restlessness. Respondent was supposed to be conducting the discogram, but there was no evidence that the discogram was conducted. There was no explanation regarding why, if the patient was not exhibiting outward signs of distress, the discogram did not take place in the 10 to 15 minutes following the immediate reinsertion of the surgical needle.

(4) Although autopsy photographs depicted injury to Donna A.'s right internal jugular vein, it was not established by clear and convincing evidence that the injury depicted was caused by the 18-gauge needle. (See Factual Finding 45(c) below.)

15(d). For the reasons set forth above, Respondent's recollection of the events set forth in Factual Finding 15(b) is more plausible than Dr. Shahangian's, and is incorporated as a Factual Finding herein.

16. At about 9:35 a.m. or 9:40 a.m., Dr. Shahangian administered dexamethasone (to treat possible allergic reaction), without any effect.

17. At approximately 9:45 a.m., Dr. Shahangian induced general anesthesia, administering propofol (to make the patient unconscious) and succynolcholine (to paralyze the muscles of the jaw and neck in order to facilitate intubation).

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[5] Effective April 10, 2007, Dr. Shahangian's Physician's and Surgeon's Certificate was fully restored to clear status, free of probation requirements.

[6] Complainant's expert, William R. Taylor, M.D., verified that it would take about 10 minutes for a hematoma to form. According to Dr. Taylor, signs of a hematoma developing in the neck include hoarseness or inability to talk, shortness of breath, gasping for air and anxiety due to inability to breathe. Additionally, one can often see a hematoma developing on the side of the neck.

18(a). Dr. Shahangian testified that Respondent stated he could not continue surgery with an agitated patient and asked Dr. Shahangian to convert from MAC to general anesthesia. Although Dr. Shahangian acknowledged that a surgeon cannot perform a provocative discogram when the patient is "asleep," he insisted that Respondent did not ask him to take the patient down further into conscious sedation. Dr. Shahangian testified that he agreed to induce general anesthesia because he wanted to respect Respondent's opinion and because he believed that a hematoma may be forming and impinging on the airway and he wanted to intubate the patient, establish an airway, and provide a means of mechanical ventilation before it was obstructed. However, Dr. Shahangian was not able to intubate Donna A.

18(b). Respondent testified that, after removal of the surgical needle and hearing that the patient's IV line had been disconnected, he felt that the patient should receive further conscious sedation as prescribed, and he made that request. Respondent insisted that he requested more/deeper sedation for the patient, asking that the patient be placed in the most sedated state. However, he denied requesting general anesthesia and also denied allowing the induction of general anesthesia. Respondent explained that he uses only local anesthesia for provocative discograms, not general anesthesia. According to Respondent, he became aware that Dr. Shahangian had induced general anesthesia when he noticed that the patient was not moving at all and the anesthesiologist acknowledged that he was trying to intubate the patient.

18(c). Dr. Shahangian's testimony regarding who decided to induce general anesthesia was not credible since provocative discograms are typically performed under local anesthesia (see Factual Finding 10) and there was no evidence that the discogram had been completed or discontinued and that Respondent was continuing with the planned discectomy (see Factual Finding 15(c)(3)).

19. After inducing general anesthesia, Dr. Shahangian attempted to intubate Donna A. two to three times, using a laryngoscope, first with a Macintosh-3 blade and then a Miller blade.[7]

20(a). Dr. Shahangian testified that he was not able to visualize the epiglottis or, below that, the vocal chords, and therefore was not able to place an endotracheal tube into the trachea. According to Dr. Shahangian, there was marked distortion/swelling of the patient's airway, with "bulging" from the right side of the patient's neck, preventing him from seeing "anything as a separate entity except the base of the tongue." Dr. Shahangian

[7] A laryngoscope consists of a handle with a light source and a blade to displace the tongue and epiglottis and visualize the vocal chords at the entrance of the trachea, in order to insert an endotracheal tube into the patient's trachea. There are two types of blades used on a laryngoscope. The Macintosh blade is a wider, curved blade and a Miller blade is straighter and thinner.

continued ventilating the patient between intubation attempts, but ventilating was "getting difficult."

20(b). Dr. Shahangian's anesthesia notes, completed immediately after the patient's death, noted his observation of "marked edema and distortion of airway."[8]

20(c). Dr. Shahangian's testimony that there was "bulging" from the right side of the patient's neck was not convincing. This observation was not noted in the anesthesia record or anesthesia notes, and it was contradicted by the respiratory therapist's note, which documented that the entire circumference of the airway was narrowed, without any observations of "bulging" from the right side (see Factual Finding 27).

21. At a time undisclosed by the evidence, Dr. Shahangian was able to insert into the patient's pharynx a laryngeal mask airway (LMA), which is used when a practitioner is unable to intubate a patient.[9] When an LMA is inserted, the air takes the path of least resistance, and if the patient's anatomy is normal, the air would enter the trachea. However, Dr. Shahangian was unable to ventilate the patient using the LMA

22. Dr. Shahangian attempted to use the LMA for about one minute, during which time he listened with a stethoscope for bilateral breath sounds and determined that ventilation was inadequate.

23. From the beginning of Dr. Shahangian's attempts to ventilate Donna A., the patient's finger was attached to a pulse oxymeter. However, Dr. Shahangian was not satisfied with the consistency of the "capture" of the patient's correct pulse by oxymetry because, at times, the machine would detect the pulse and at other times it did not. Consequently, an auxiliary pulse oxymeter was brought in and attached to another of Donna A.'s fingers.

24. At approximately 9:55 a.m., Dr. Shahangian told Respondent that it was getting difficult to ventilate the patient and that he needed Respondent to establish a surgical airway via an emergency tracheostomy. Respondent asked for a tracheostomy tray, and once it was provided, Respondent made an incision in the skin on the patient's neck. However, around 10:00 or 10:05 a.m., Respondent stopped the procedure and closed the incision in Donna A.'s neck. Dr. Shahangian resumed with manual ventilation of the patient by way of an Ambu-bag.[10]

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[8] Edema is the swelling of soft tissues as a result of excess fluid/water accumulation.

[9] An LMA is an alternative method of airway management. An LMA includes a tube with an inflatable cuff that is inserted into the pharynx. The device sits tightly over the top of the larynx and the cuff is inflated with air to create a seal.

[10] An Ambu-bag is a hand-held device used to provide ventilation to a patient who is not breathing or who is breathing inadequately.

25(a). Dr. Shahangian testified that Respondent was unable to create a surgical airway because Respondent, by his admission, had not done tracheostomy for many years and had forgotten how perform the procedure. Dr. Shahangian testified that, despite his insistence that the procedure must be done or the patient would die, Respondent aborted the procedure.

25(b). In his testimony, Respondent admitted that, during the time he was making the skin incision, he was uneasy because he had not performed a tracheostomy for many years. Respondent also testified that the first pulse oxymeter attached to Donna A. had oxygen (O2) saturation readings of approximately 60, but that during the time he was beginning the tracheostomy, he was able to see that second pulse oxymeter showed O2 saturation of up to 98 and 100. According to Respondent, this indicated adequate ventilation and no need for continuing the tracheotomy, so he closed the incision. Respondent insisted that, at the time he stopped the tracheostomy, Donna A. was being oxygenated.

25(c). Although Donna A.'s medical records contained data strips from a pulse oxymeter indicating O2 saturation of 100 percent at 10:12 a.m., it was not established that those readings were taken from the machine which Respondent visualized during his attempted tracheostomy. Additionally, Respondent admitted that he did not know if the readings reflected the first or second machine, although he believed they were from the second because the readings reflected what he saw when the second machine was "hooked up."

25(d). In a statement given to a Board investigator on August 27, 2003, Respondent recalled problems with the pulse oxymeter readings. Based on Respondent's August 27, 2003 statement, the first pulse oxymeter was the machine with the 100 percent O2 saturation readings and those 100 percent readings were incorrect. Respondent stated, "One [pulse oxymeter] said 100 percent, and myself and my assistant [said] it's impossible [because] the patient [had not been] intubated for [so] long, so they brought another one in that showed zero percent."

25(e). Respondent's recollection of the 100 percent O2 saturation level being the sole reason for aborting the tracheostomy was not persuasive. It was not established that a reliable pulse oxymeter indicated 100 percent O2 saturation at the time Respondent attempted his tracheostomy. While one of the oxymeters may have displayed such a reading, it is questionable that Respondent would have relied upon it, given his statement that the 100 percent reading was "impossible." It is more plausible that, in his reluctance to proceed with the tracheostomy, Respondent relied upon what may have been a faulty oxymeter reading to justify closure of the incision. It is equally plausible that Respondent is now using the faulty reading, after the fact, to justify aborting the tracheostomy, although he did not rely on the reading at the time. Regardless of when he began to rely on the O2 saturation readings as justification, the evidence established that Respondent aborted the tracheostomy based on his reluctance to perform the procedure, having not performed one for many years.

26. At approximately 10:10 a.m., a respiratory therapist, Jim Hutchison (Hutchison), was called in, by request of Respondent, to attempt intubation. At that point, Dr. Shahangian was providing manual ventilation to the patient by way of an Ambu-bag. Dr. Shahangian did not immediately allow Hutchison to do so because Dr. Shahangian believed that, according to the guidelines of the American Society of Anesthesiologists, a practitioner should limit the number of attempts at intubation, as each attempt invokes more damage to the tissue, which may lead from a partial obstruction of an airway to a complete obstruction. However, Dr. Shahangian did eventually relent and allow Hutchison to attempt intubation. In doing so, Dr. Shahangian had to stop "bagging" the patient, since Hutchison had to visualize the patient's mouth and throat.

27. Prior to attempting intubation, Hutchison noted an incision in Donna A.'s neck from Respondent's aborted tracheostomy. According to Hutchison's respiratory therapy note, when he inserted the laryngoscope into the patient's pharynx and applied upward force, he was unable to visualize the epiglottis because the "entire circumference of [the] airway [was] narrowed down at [the] level of [the] vallecula."[11] Hutchison attempted a "blind pass" of the endotracheal tube, distal and superior to the vallecula. However, upon auscultation and reading of the carbon dioxide measurements, he determined that there was no ventilation through the endotracheal tube. He continued to assist with the bag ventilation.

28. At 10:14 a.m., after Hutchison's unsuccessful attempt at intubation, Dr. Shahangian called a Code Blue, and asked the nurse supervisor to a summon a general surgeon or someone who could perform a tracheostomy.

29. Following the Code Blue, Advanced Cardiac Life Support (ACLS) efforts were undertaken by Dr. Shahangian, Hutchison and others. Thereafter, Donna A. developed bradycardia and suffered cardiac arrest prior to 10:55 a.m., at which time defibrillations began.

30. Between approximately 11:05 and 11:10 a.m., thoracic surgeon Alfonse Miguel, M.D. arrived. At 11:14 a.m., Dr. Miguel successfully performed a tracheostomy on Donna A. that provided ventilation to the patient.

31. Dr. Miguel's operative report, dated November 26, 2002, stated, *inter alia*:

> [I] opened the previous incision in the neck area and a significant amount of venous blood was oozing; however, this was controlled by putting pressure on the area and I was able to dissect the second tracheal ring and T slit was made and a #6 tracheostomy tube was inserted without any difficulty and then connected to ventilator. . . . The cardiopulmonary resuscitation was continued at this point and [Dr. Miguel placed a triple-lumen venous catheter].

[11] The epiglottic vallecula is a depression just behind the root of the tongue between the folds in the throat.

32. ACLS efforts continued, but the patient expired at 11:39 a.m.

33(a). At the administrative hearing, the parties offered disparate evidence regarding whether Respondent remained in the OR and assisted during the ACLS efforts between 10:14 a.m. and 11:05 a.m.

33(b). Dr. Shahangian recalled that, after Hutchison's unsuccessful attempt at intubation, Respondent left the OR and did not return until about one hour later, about the time Dr. Miguel arrived.

33(c). The parties stipulated Susan Montgomery, R.N., would testify that she did not see Respondent administering chest compressions to Donna A. Nurse Montgomery was the circulating nurse and arrest team nurse for Donna A. on November 26, 2002.

33(d). In his testimony, Respondent recalled that, in response to the Code Blue, he began doing chest compressions on Donna A. until the thoracic surgeon arrived. However, in his August 27, 2003 statement to the Board investigator, Respondent never asserted that he administered chest compressions to Donna A. Instead, Respondent recalled that, with the patient "already in cardiac arrest mode," he had "just barely started [making the incision] to see if we could start a tracheostomy," when Dr. Miguel came in to take over. According to Respondent, upon making the incision, there was not much bleeding and the blood was dark.

33(e). Respondent's August 27, 2003 recollection of events was erroneous, since the evidence established that, by the time Dr. Miguel arrived, Respondent had made and closed the incision, Hutchison had attempted intubation and ACLS efforts had continued for almost an hour. However, the invalidity of Respondent's prior statement does not validate his current recollection that he administered chest compressions, particularly in light of Dr. Shahangian's recollection that Respondent left the OR and in light of nurse Montgomery's recollection, as the circulating and arrest team nurse, that she did not see Respondent administering chest compressions. Nevertheless, since Dr. Shahangian was admittedly involved in ACLS efforts, it is questionable that he was keeping track of whether Respondent was absent from the OR the entire time that ACLS was being employed.

33(f). The evidence established that Respondent did not assist during the ACLS efforts between 10:14 a.m. and 11:05 a.m. The evidence did not establish that he was absent from the OR during the entire time period from 10:14 a.m. to 11:05 a.m.

34(a). At the administrative hearing, the parties offered disparate evidence regarding whether Respondent assisted Dr. Miguel with his successful tracheostomy.

34(b). In his operative report, Dr. Miguel listed "Jae Chu, M.D." as his assistant for surgery. However, Dr. Miguel testified at the administrative hearing that Respondent did not assist him with the tracheostomy and that he only had a "glimpse" of Respondent during the procedure. He stated that, prior to performing the tracheostomy, he had no conversations with Respondent and that he did not see Respondent doing anything with the patient during

the procedure. Other than Dr. Shahangian, Dr. Miguel saw no other person in the OR that he recognized to be a physician. He provided no explanation for how "Jae Chu," a name similar to "J. Chiu," would have come to be listed in his operative report as his assistant.

34(c). The parties stipulated Susan Montgomery, R.N., would testify that she did not see Respondent assisting Dr. Miguel in any way with the tracheostomy on November 26, 2002.

34(d). In his testimony, Respondent recalled assisting Dr. Miguel with the tracheostomy by sponging the blood with gauze and helping to cut sutures. He testified that he also suggested to Dr. Miguel to establish the central venous line to facilitate medication and blood administration.

34(e). The evidence established that, although Respondent was present in the OR when Dr. Miguel performed his successful tracheostomy, Respondent did not assist Dr. Miguel with that procedure.

35(a). At the administrative hearing, the parties offered disparate evidence regarding the appearance of Donna A.'s neck and any observed formation of a hematoma following the insertion and withdrawal of the 18 gauge surgical needle.

35(b). Dr. Shahangian testified, and his anesthesia notes and anesthesia record indicate, that he noticed some edema or swelling in the patient's neck. He conceded that it was diffused swelling, rather than a discrete bump, and that it was restricted to a two-inch by three-inch area around the "area of surgery," in middle of the patient's neck, toward the right side. He insisted that the swelling was compatible with a hematoma near the surgical site, which was not profound but later became bigger.

35(c). Respondent testified that there was no change in the patient's neck after he removed the needle from her neck and that he did not believe a hematoma was forming. He insisted that, from the time he removed the needle until Dr. Miguel arrived, he did not see any discrete, significant hematoma at the level of the larynx and around the trachea. He also did not recall any swelling in her neck, but noted that the patient's neck was "always fat and short."

35(d). Dr. Miguel testified that, prior to performing his tracheostomy, he assessed Donna A.'s neck and noted a significant amount of swelling in the neck. He recalled that the neck was markedly swollen "by some type of edema or bleeding into the area." Although a cricothyrotomy[12] would have been "faster" to perform, there was so much swelling that he could not determine where the cricothyroid membrane was, so he decided to perform a tracheostomy by opening the prior incision. During his testimony, when asked if he

[12] A cricothyrotomy is an emergency incision through the skin and cricothyroid membrane to secure a patient's airway.

observed any evidence of a hematoma, he stated that, once he opened the incision, "a lot" of dark blood came oozing out of the wound.

35(e). The evidence established that there was edema / swelling in Donna A.'s neck following the reinsertion of the 18 gauge surgical needle. However, Complainant did not establish, by clear and convincing evidence, that anybody ever observed a discrete hematoma developing in Donna A.'s neck as a result of the insertion of the surgical needle (See also, Factual Finding 46, below).

36. None of the witnesses (Dr. Shahangian, Hutchison, Dr. Miguel and Respondent) observed any deformity, distortion or displacement of the trachea. Additionally, none of them noted any evidence of tracheomalacia (tracheal collapse).

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37. Following Donna A.'s death, the case was referred to the Los Angeles County Coroner's (Coroner) office. The case was assigned to Susan Selser, M.D., who conducted the autopsy on December 1, 2002.

38. In the records forwarded to the Coroner's office was Respondent's OR note, which stated, "[Patient] was extremely restless under local and MAC anesthesia while beginning discogram (or insertion of needle)."

39(a). Dr. Selser issued an autopsy report on March 11, 2003. That report indicated the following:

> Neck Dissection:
> [R]ather extensive hemorrhage and early decomposition change are present. No edema is noted along the larynx. . . . There is abundant hemorrhage along the posterior soft tissues of the pharynx and strap muscles. . . . The tongue on section shows focal areas of lateral hemorrhage, small.
>
> [¶ . . .¶]
>
> Diagnoses [from Microscopic Report]:
>
> Large submucosal hemorrhage in multiple sections of the posterior pharynx with mucosal disruption. . . .

39(b). In her March 11, 2003 report, Dr. Selser did not note any damage to the patient's right internal jugular vein. However, autopsy pictures were taken of the right and left internal jugular veins depicting some injury to the right internal jugular vein and hemorrhage in that area.

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39(c). An anesthesiology consult by a Dr. Hendrickson, dated February 3, 2003, and contained in the March 11, 2003 report noted, among other things:

> [A] surgical needle was inserted by the surgeon and reported to bleed somewhat. . . .
>
> 0925 she was agitated, hoarse, coughing, restless, and was given Dexamethasone, lidocaine, and 50 mg propofol. 02 Sat 99. There was no visible edema.
>
> 0950 MAC was converted to general anesthesia with lidocaine 30 mg, propofol 100 mg, succinylcholine 180 mg. . . . She could not be intubated, nor ventilated with LMA; efforts by MD and RT. There was marked edema and distortion of the airway; the epiglottis could not be seen.
>
> Tracheostomy was attempted, but there was much blood in the anterior neck, and it was unsuccessful. . . .
>
> [¶ . . .¶]
>
> IMPRESSION:
>
> 1. Inability to establish an airway in a person of body habitus associated with high anterior larynx, very short neck (?webbed), anterior cervical curvature, full set of teeth, and obesity.
>
> 2. What caused the original airway problem? ? allergy, response to pain, momentary loss of airway patency? I don't know. Drugs usage was appropriate.

39(d). Dr. Selser's opinion, stated in the March 11, 2003 autopsy report was that, "[t]he cause of death is cardiorespiratory arrest due to failure to establish airway due to short neck (web neck) obesity."

40. After reading the March 11, 2003 autopsy report, Dr. Shahangian called the Coroner's office to discuss the contents of that report. Dr. Shahangian spoke with a man who was a "Director or Chair" at the Coroner's office, and he also wrote a letter to the Coroner on April 23, 2003. Dr. Shahangian informed the Coroner that he believed their office had not been informed that the patient's surgery had commenced and that they had the erroneous impression that he had decided to induce general anesthesia without any previous surgical attempt. He further informed the Coroner that, when the examiner had seen the patient's neck, it was not in the same state as it was previously, when a "huge hematoma" had been present. Dr. Shahangian explained the chain of events as he recalled them and

stated that forceful intubation was unlikely to cause retropharyngeal hemorrhage without signs of trauma in other areas, including the esophagus.[13]

41(a) Dr. Selser completed a supplemental autopsy report on May 7, 2003, following additional information received in Dr. Shahangian's April 23, 2003 letter. This supplemental autopsy report was included in the final Coroner's case report, issued after May 7, 2003.

41(b). Dr. Selser's supplemental autopsy report stated:

> From the clinical circumstances reported it is apparent a significant hematoma was developing in the neck prior to intubation/resuscitation efforts. The apparent trauma of the right internal jugular vein, see autopsy photos, appears consistent with the source of the bleeding.
>
> It is likely the resultant evolving hematoma complicated efforts at airway placement, see supplemental anesthesiology consultant report of Dr. Hendrickson, 4-29-03.
>
> The Death Certificate has been amended to reflect this additional factor in the death as reflected above.

41(c). Also contained in the Final Coroner's Report was a supplemental anesthesiology report, dated April 29, 2003, which stated:

> This supplemental anesthesiology report is to add to the original anesthesiology report signed on February 3, 2003.
>
> From information received today from the Deputy Medical Examiner, Dr. Susan Selser and Chief Medical Examiner-Coroner, Dr. Lakshmanan Sathyavagiswaran, the following information is added to the original report under IMPRESSION, paragraph #2.
>
> > "A large hematoma formed in the right neck after insertion of a surgical needle. This caused external pressure on the airway, with difficulty in the airway management by LMA, by intubation, and by tracheostomy."

41(d). In the Final Coronor's Report, the patient's cause of death was changed to cardiorespiratory arrest due to failure to establish an airway due to short neck (web neck), obesity and neck hematoma.

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[13] In his testimony, Dr. Shahangian continued his assertion that he did not tear the posterior pharynx and insisted that he "had nothing to do with the posterior pharynx."

42. Contrary to Dr. Shahangian's claim that the Coroner did not know about the commencement of surgery, the initial anesthesiology consult noted the needle insertion and observation of blood. The anesthesiology consult also mentioned the patient's agitation, hoarseness, coughing and restlessness, and the marked edema and distortion of the airway, yet the consulting anesthesiologist did not independently conclude, or even suggest, that a hematoma may have formed. Additionally, although photographs were taken of the right internal jugular vein showing some injury and hemorrhage in that area, Dr. Selser did not mention it in her initial report. The amended findings in the Final Coroner's Report were based on the assertions by Dr. Shahangian, and not on any independent assessment by the consulting anesthesiologist or Dr. Selser, that a hematoma may have formed in the patient's neck. Since Dr. Shahangian's assertions, as well his motives in providing the information to the Coroner, were questionable, the amended findings in the Final Autopsy Report are given less weight than those in the March 11, 2003 autopsy report.

43. In Donna A.'s initial Certificate of Death, issued December 3, 2002, the cause of death was listed as "deferred." On February 13, 2003, an amendment to the death certificate (amended death certificate) was issued, and the cause of death was listed as "cardiorespiratory arrest, failure to establish airway and short neck (web neck) obesity." The amended death certificate indicated that the November 26, 2002 operation had "not yet" been performed, but that there was the "beginning of general anesthesia." The amended death certificate also listed the "events which resulted in injury" as "unable to establish airway."

44. On July 7, 2003, Donna A.'s death certificate (final death certificate) was again amended to reflect the cause of death as cardiorespiratory arrest, failure to establish airway, short neck (web neck) obesity and neck hematoma. In the section regarding whether the operation had been performed, the final death certificate indicated that there had been "trochar placement for attempted cervical discogram." The final death certificate also listed the "events which resulted in injury" as "unable to establish airway following attempted trochar placement.

45(a). At the administrative hearing, Dr. Selser testified credibly that she observed mucosal disruption above Donna A.'s airway and that the whole area was hemorrhagic, confluent in the back of the pharynx and lateral sides of neck and also around the injury of the internal jugular vein. Dr. Selser opined that the extensive trauma to the mucosa in the retropharyngeal area and the extensive bleeding in that area was probably related to the difficult intubation efforts.

45(b). At the time of autopsy, Dr. Selser did not, and could not, observe any deviation of the patient's airway caused by a hematoma. She could not opine regarding any deformation, distortion or displacement of the trachea since, upon dissection, the original integrity of organs was disturbed, and she was unable to see the neck *in situ* in order to determine what had existed before.

45(c). Dr. Selser explained that she did not describe the disruptions in the right internal jugular vein in her original autopsy report because she did not think it was an injury at the time. According to Dr. Selser, it was clear that there was extensive blood in the area which was not supposed to be there. She was "struck by the hemorrhage" and "disturbed by what it meant." However, at time of autopsy, she believed that nothing had been placed into the patient's neck. Therefore, her focus was on what happened during intubation efforts and the inability to save the patient. She was later made aware that a needle had been placed in the patient's neck and that the "difficulty" with the patient began before intubation and resuscitation attempts. Dr. Selser could not determine from the autopsy alone where the blood came from, but needed to put her findings together with the time sequences provided to her. Based on her autopsy findings, her review of all records, including Dr. Miguel's report, and the input from Dr. Shahangian, Dr. Selser determined that the blood she found had most likely come from the injury she observed in right internal jugular vein. However, Dr. Selser could not rule out that Respondent's attempt at a tracheostomy created the blood in the patient's neck. She also could not rule out that Dr. Miguel's incision caused some of the bleeding. She conceded that the blood could be related to resuscitative efforts and that it was not possible, at time of autopsy, to separate those out.

45(d). Dr. Selser did not testify that the injury to the right internal jugular vein and the hemorrhage observed was evidence of a previously-existing hematoma.

46(a). At the administrative hearing, Respondent offered the credible testimonies of William Klein, M.D., a pulmonary disease specialist; Richard Ruffalo, M.D., an anesthesiologist; Martin Krell, M.D., a neurosurgeon; and Vert Mooney, M.D., an orthopedic surgeon, to testify regarding the likelihood of a hematoma forming in a patient's neck following the puncturing of the internal jugular vein and the likelihood that any such hematoma would deviate the trachea. Their testimonies collectively established Factual Findings 46(b) through 46(f).

46(b). It is very unlikely that a hematoma large enough to deviate the trachea could result from a puncture of the internal jugular vein by an 18 gauge needle. The carotid artery and the internal jugular vein are encased in the carotid sheath and surrounded by the sternocleidomastoid and other smaller muscles, which are, in turn, surrounded by fascia, then fatty/subcutaneous tissue and then skin. The muscles, fascia and fat help to stop the formation of hematomas around the internal jugular vein by applying natural pressure, or "tamponade," against the already low pressure system of the vein, which aids in clot formation. A nick of the internal jugular vein could leak for about 10 minutes, but then "tamponade" would take effect. While hematomas can sometimes form from a nick to the internal jugular vein, they typically create only a slight bulging from one to two and one half centimeters in diameter, and they are never large enough to deviate, deform or collapse the trachea.

46(c). The patient's symptoms did not demonstrate the formation of a hematoma which deviated, deformed or collapsed her trachea. At time the 18 gauge needle was removed from her neck and the patient was talking to the nurses, there was no evidence of

any hematoma formation. Since the patient was able to talk and, therefore, able to breathe after the needle was removed, she was in no respiratory distress at that time. Additionally, none of the records indicate that she complained of not being able to breathe at any time prior to being placed under general anesthesia. If a trachea is blocked, displaced or collapsed, this can create "stridor," which is a deep, throaty sound, or squeaky noises, or wheezes. There was no evidence of any stridor or wheezing in the patient's records. While the patient's voice was described as hoarse and "squeaky," this alone did not indicate the formation of hematoma that was displacing her trachea. The hoarseness can be attributed to factors other than a hematoma, such as post-nasal drip.[14] Moreover, the hoarseness or squeakiness in her voice coincided with a time when her blood saturation and heart rate were normal, which would not indicate any problem with her airway. There was never any evidence of a hematoma in the laryngeal area, created by the surgical needle, which distorted the patient's trachea and made it difficult or impossible to ventilate the patient.

46(d). There was never any evidence of a hematoma in the retropharyngeal area causing the concentric narrowing that made it impossible for Dr. Shahangian to intubate the patient. It is anatomically impossible for hemorrhage from the low pressure internal jugular vein, caused by insertion of an 18 gauge needle at the C4-C5 level, to travel to the retropharyngeal area, because that would require several hours of continuous bleeding, which would not occur due to the pressure of the surrounding fascia and muscles. The fascia and muscles would also act as barriers to the blood flowing back upward. Additionally, even if a hematoma was able to work its way up, it would dissipate as it traveled. Instead, the edema and hemorrhage that were found in the retropharyngeal area came from the intubation efforts of Dr. Shahangian. (See also Selser opinion in Factual Finding 45(a).) When a laryngoscope blade touches the retropharynx, it traumatizes the sensitive tissue and can cause more edema and hemorrhage with each successive intubation effort. Multiple attempts may cause a narrowing of the airway which makes subsequent attempts at intubation virtually impossible.

46(e). It is implausible that the lacerations to the internal jugular vein noted by Dr. Selser were caused by the 18 gauge needle.

46(f). While a hematoma may have formed in Donna A.'s neck, this occurred after Respondent's initial tracheostomy attempt. When performing a tracheostomy, the surgeon must cut through arteries and veins, which can cause significant bleeding. Therefore, the accumulation of blood observed by Dr. Miguel was probably caused by Respondent's prior tracheostomy attempt. However, it is unlikely that any hematoma following Respondent's attempted tracheostomy caused deformation of the trachea. In an obese person, lying on her

[14] In coming to their conclusions, Respondent's experts relied on the deposition testimony of OR nurses Anne Dale and Susan Montgomery that, contemporaneous with her coughing and restlessness, Donna A. stated that she had post nasal drip and wanted to irrigate her sinuses prior to surgery, but was not allowed. The experts' reliance on these deposition testimonies was reasonable, given Donna A.'s history of allergic rhinitis (See Factual Finding 7).

back the airway can collapse on itself, but not the trachea. The cartilage surrounding the trachea keeps the trachea open, and it takes tremendous pressure to collapse it.

47(a). In the Second Amended Accusation, page 5, paragraph 11, lines 19 through 21, Complainant alleged,

> Within ten minutes, the patient began coughing and became hoarse, agitated and restless due to a hematoma developing in her neck. Dr. Shahangian reported that when Dr. Chiu withdrew the needle from Donna A.'s neck, "blood was flushing out."

47(b). Complainant did not establish, by clear and convincing evidence, that blood was "flushing out" of the needle when Respondent withdrew it from Donna A.'s neck or that the patient's agitation was due to a hematoma developing in her neck.

48(a). In the Second Amended Accusation, page 6, paragraph 14, lines 23 through 26, and paragraph 15, line 28, Complainant alleged,

> [Respondent's] decision to allow the induction of general anesthesia in response to Donna A.'s coughing and her becoming hoarse, agitated and restless and her developing hematoma departed from the standard of care. . . .
>
> [R] Respondent deviated from the standard of care by inducing general anesthesia. . . .

48(b). Complainant did not establish, by clear and convincing evidence, that Respondent made the decision to allow the induction of general anesthesia or that he "induced general anesthesia."

Facts Re: Respondent's Treatment of Patient John C.

49. Patient John C., a 79-year-old male, was first seen by Respondent on May 31, 2002. His chief complaint was intractable and increasing low back and leg pain, with the left leg pain greater than right leg pain. John C. had a medical history which included two heart bypass surgeries in 1975 and 1985, gallbladder and appendix surgeries, cervical laminectomies in 1972 and 1997, angioplasty in 2001, and pulmonary embolism in 2002.

50. According to Respondent's May 31, 2002 consultation report, he conducted a neurological examination of John C. on that date which revealed the following:

> He was in distress from spinal pain. There was paralumbar vertebral muscle tenderness and muscle spasm at +1 to 2 with -1to 2 limitation of low back movement. Straight leg raising was 75° on the right and 65°

on the left. Ankle jerk was +1 bilaterally. Pain and touch sensation was -1 to 2 for dorsal and lateral aspect of the left foot and ankle.

[¶] . . . [¶]

Muscle strength was grossly intact. Gait was normal. Tandem was normal. Alternate movement rates and coordination were good.

51. On May 31, 2002, Respondent diagnosed John C. with degenerative lumbar disk disease, with stenosis and radiculopathy. Respondent's recommendations included the following:

1. X-rays of appropriate areas for assessment;
2. Updated MRI scan of lumbar spine for further evaluation;
3. CT scan of lumbar spine for further evaluation;
4. EMG of bilateral lower extremities for further assessment . . ."

I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms/herniation/spondylosis with lumbar radiculopathy symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedures of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications.

52. On May 31, 2002, an EMG of John C's lower extremities revealed bilatereal radiculopathy at L5 and left S1 radiculopathy. A CT scan of his lumbar spine taken the same day revealed the following:

1. L1-2: broad 1-2mm disc protrusion.
2. L2-3: broad 1-2 mm disc protrusion.
3. L3-4: 3 mm disc protrusion extending into both neural foraminal exit zones, left greater than right.
4. L4-5: 4-5 mm disc protrusion with grade 2 spondylolisthesis.
5. L5-S1: 4mm disc protrusion.

53. On June 7, 2002, x-rays were taken of John C.'s lumbar spine.

54. On August 6, 2002, an MRI was performed on John C.'s thoracolumbar spine by Robert Princenthal, M.D. of Medical Imaging Medical Group. His impressions were:

1. Severe degenerative facet joint changes L4-5 resulting in a 2-3 mm anterolisthsiasis [*sic*] of L4-5 and contributing to a moderate central canal stenosis.
2. 3-MM, perhaps 4-MM central and slightly left paracentral disc

protrusion at L5-S1 encroaching on the lateral recess on the left.
3. Minimal disc bulge L1-2 centrally (2-MM).

55. On August 15, 2002, Respondent conducted a preoperative history and physical on John C. Respondent's August 15, 2002 history and physical examination report documented Respondent's review of the May 31, 2002 EMG findings and the findings from the patient's September 6, 2001 MRI of his lumbosacral spine, which indicated a history of low back pain and right leg pain and the following impressions:

1. Grade I degenerative spondylolisthesis with moderately severe right latereal recess/proximal foraminal stenosis at L4-5 and mild central canal stenosis also present at this level.
2. Osteoarthritic facet joints also present at L5-S1 with prominent left lateral recess and foraminal stenosis present at this level.
3. Small generalized disc bulge at L1-2.

56(a). Respondent's August 15, 2002 neurological examination produced findings identical to those from the May 31, 2002 examination. In the Recommendations section of the August 15, 2002 report, Respondent noted:

> I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms/herniation/spondylosis with lumbar radiculopathy symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedures of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty and the possible risks and complications. They wished to go ahead with the surgery immediately because of severe intractable symptoms.

56(b). Respondent's uncontradicted testimony established that, although he did not list all of the alternatives, risks and complications of the procedures in his report, he did discuss them with the patient. In addition to his discussion with the patient, he had pamphlets and books available regarding risks and complications of the procedures, and that he had a brochure available on the Internet as well.

57(a). On August 16, 2002, John C. was admitted to Pacific Hospial in Long Beach, California. Respondent performed a provocative lumbar discogram and a microdecompressive endoscopic lumbar discectomy with laser thermodiskoplasty. Respondent's August 16, 2002 operative report indicated that local/MAC anesthesia was used for these procedures. The operative report contained a description of the operation, which included the following:

> [A]fter regular prep and drape and under .5% local Xylocaine anesthesia, provocative lumbar discogram of L3, L4 was performed with left posterolateral approach and L5 with left transpinal approach

with 3 cc. Ominipaque dye injected under digital pressure with positive reproduction of preoperative pain and abnormal discogram of L3, L4 and L5 noted.

57(b). At the administrative hearing, Respondent asserted that the operative report documented the patient's level of consciousness, since it indicated that local/MAC anesthesia was used and it indicated that the patient was awake and able to respond. He noted that the phrase "positive reproduction of preoperative pain" means that the patient responded verbally, confirmed that he felt pain and described the pain.

57(c). There was no evidence to contradict Respondent's assertion that John C. responded verbally, confirmed that he felt pain and described the pain.

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58. John C. was discharged from Pacific Hospital on August 16, 2002.

59. John C. visited Respondent's office on August 29, 2002. In an August 29, 2002 progress note, Respondent documented that the patient's left leg pain was better and that there was no lower back pain or numbness. He noted that the patient's right leg pain was continuing and that the patient experienced a "slight right limp at times." He also noted that the patient was "ambulating – ok." Straight leg raising (SLR) tests conducted that day produced findings of "75°/75°." Respondent prescribed Neurontin and bilateral sacroiliac (SI) joint trigger point injections and recommended that the patient return in three weeks.

60. The SI trigger point injections were administered on August 29, 2002. X-rays of John C.'s lumbosacral spine, taken that same day, revealed "degenerative change at L4-5 and L5-S1 with grade 1 anterolisthesis of L4 in reference to L5."

61. On September 17, 2002, John C. returned to Respondent's office. Respondent's progress note from that date noted that the patient's right leg pain was continuing. SLR tests conducted that day revealed the same findings as on August 29, 2002. Respondent prescribed Neurontin, an EMG on the patient's right leg for evaluation, SI joint trigger point injections, and a CT scan of the patient's lumbar spine for assessment. Respondent recommended that the patient return in three weeks.

62. On September 17, 2002, SI trigger point injections were administered. The recommended EMG was conducted, with the following findings: "Findings are commensurate with right L5 radiculopathy. Clinical correlation is suggested for these findings." A CT scan was also conducted, with the following findings and impression:

FINDINGS:

[L]4-5: Broad based 4-5 mm disc is again identified extending into both lateral recesses. Again noted is a bilateral spondylolisthesis with minimal subluxation.

L3-4: 2-3 mm biforaminal disc bulges are seen peripherally left greater than right. This extends into the left lateral recess with mild involvement of the left exiting L3 nerve root.

L2-3: Biforaminal 2-mm bulges are noted extending into the lateral process.

L10-2: 2-mm annular bulge is seen in midline.

[¶] . . . [¶]

IMPRESSION:

Findings show similar changes to the prior MR. Pertinent large discs are seen at L4-5 and L5-S1. Facet joint hypertrophic spurring and spondylolysis is seen at the L4-5 level. There is evidence of spondylolysis particularly on the left at L5 contributing to this finding. Biforaminal discs are seen at L3-4 and L2-3.

63. At the administrative hearing, Respondent maintained that he addressed appropriately any new neurological findings reported by John C. following the operation. Respondent asserted that John C. did not have a "foot drop" when he saw him, that neither the August 29 or September 17, 2002 notes documents a foot drop, and that the patient did not complain of that problem until after he had left Respondent's care.

64. Respondent contended that he did not recommend an MRI on August 29 or September 17, 2002, because the patient did not want an MRI and because the patient was an older man who "cannot tolerate an MRI of that length of time." Respondent noted that an MRI takes 20 to 30 minutes, during which the patient must be lying down, and that a CT scan takes only five minutes. However, Respondent's position is belied by the fact that John C. could tolerate undergoing an MRI, and had tolerated MRIs on September 6, 2001, and August 6, 2002. John C. also tolerated an MRI on October 3, 2002, after leaving Respondent's care. Consequently, the evidence established that an MRI was a viable option available for Respondent to recommend.

65(a). In the Second Amended Accusation, page 9, paragraph 27, lines 18 through 21, Complainant alleged,

> The standard of care required that Respondent document all post-operative checks in the patient's chart. Respondent failed to document the patient's post operative visits on August 29, 2002 and September 17, 2002, and thereby departed from the standard of care.

65(b). When Respondent originally produced John C.'s records to the Board, they did not contain the progress notes from the August 29 and September 17, 2002 visits, and some

other prior visits. Respondent explained that he had employed his staff and his attorney to send copies of John C.'s chart to the Board, but that he subsequently discovered that part of chart had not been sent. In his office, one side of the patient's file is used to hold the clinical charts and one side is used to hold the business/insurance documents. The August 29 and September 17, 2002 notes had inadvertently been placed on the business/insurance side of the chart, which was not produced to the Board. When Respondent discovered this error, he produced the additional chart documents to the Board. These additional documents were contained in Complainant's exhibits at the hearing and used, in part, to establish the facts set forth in Factual Findings 59 and 61, above.

65(c). Complainant did not establish, by clear and convincing evidence, that Respondent failed to document the patient's post operative visits on August 29, 2002 and September 17, 2002.

Facts Re: Respondent's Treatment of Patient Steve F.

66. Steve F. was first seen by Respondent on January 22, 2001, after traveling from his home in Madera, California to Respondent's office in Thousand Oaks. Steve F. sought a consultation with Respondent because he had been spending weeks in bed due to pain down one of his legs which prevented him from doing his work. At that first visit, Steve F. complained of lower back pain. Respondent conducted an examination and reviewed the patient's prior MRI scan films dated December 27, 2000. Respondent ordered an EMG, which was performed that same day.[15] The EMG revealed radiculopathy on the left at L5-S1. Respondent diagnosed Steve F. with herniated lumbar discs with lumbar spondylosis and lumbar radiculopathy. On that day, Respondent also ordered an MRI of the pelvis and retroperitoneal area.[16] Respondent recommended that Steve F. undergo a discogram followed by an endoscopic discectomy with laser.[17]

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[15] The medical records indicate that the January 22, 2001 EMG was signed by Dr. Thomas Clifford and cc'd to Guy Rogers, D.C. In their testimonies at the administrative hearing, Steve F. and his wife Susan F. were adamant that Dr. Clifford never performed a test on Steve F. Instead they recalled the EMG being performed by a chiropractor named Dr. Rogers. They recalled Respondent introducing them to Dr. Clifford, but that meeting lasted only 10 seconds. The evidence did not contradict their testimonies.

[16] The MRI was performed on January 27, 2001, with normal findings.

[17] The medical records indicate that Respondent administered bilateral nerve blocks at L4, L5 and S1. However, in his testimony at the administrative hearing, Steve F. did not recall receiving this treatment.

67. In a January 2, 2001 Neurological Evaluation report, Respondent stated:

> I discussed with the patient at length regarding his intractable lumbar disc symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the procedure of provocative lumbar discogram first for confirmation prior to microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty, and its possible risks and complications. He wished to go ahead with the procedure due to his severe intractable lumbar symptoms.

68. Steve F. signed an Informed Consent form, dated February 2, 2001, consenting to the lumbar discogram and lumbar discectomy, which indicated:

> I have been informed that there are certain risks in the operation(s) and complications may occur at surgery and in the post operative period. I have been fully informed of the nature of the surgery and the purpose for which it is performed. I have been informed of other alternative methods of treatment.

69. A History and Physical Examination Report, dated February 7, 2001, mirrored the findings in the January 22, 2001 Neurological Evaluation Report. The Recommendations section of the History and Physical Examination Report indicated:

> I discussed with the patient and his wife at length regarding his intractable lumbar disc symptoms, physical findings, MRI scan/EMG findings and further alternatives of treatment and the surgery of provocative lumbar discogram and microdecompressive endoscopic lumbar discectomy with Holmium laser thermodiskoplasty, and possible risks and complications. They wished to go ahead with the surgery because of severe, intractable symptoms.

70(a). At the administrative hearing, Respondent maintained that he discusses the alternatives, risks and complications of the procedures with patients and that the patients are shown a film before they decide to proceed with the recommended treatment.

70(b). Steve F. insisted that Respondent did not tell him about any possible risks, complications or alternatives of the procedures. Respondent definitely did not tell him that he could suffer from an infection, hematoma, vascular injury, nerve damage, being operated on the wrong level, soft tissue injuries. Steve F.'s wife, Susan F. confirmed in her testimony that Respondent did not tell them that one of the complications of procedure was infection. Steve F. testified that Respondent said that he could make him well, that the procedure was simple and that there were no complications. Steve F. did not recall reading the informed consent forms before signing them.

70(c). Steve F.'s testimony that Respondent told him that there were "no complications" from the procedure was not credible and appears to be an exaggeration. It seems very unlikely that Respondent would have made such brash assertion, particularly given his attempts to document the patient's informed consent. Nevertheless, it is credible that Steve F. was not informed of all of the risks, complications and alternatives of the procedures. Despite Steve F.'s signature on two informed consent forms (See Factual Findings 68 and 73), generally confirming that he had been informed of the risks, complications and alternatives to the proposed procedures, none of the evidence established what risks, complications and alternatives, if any, Steve F. was advised about. None of these risks, complications or alternatives was listed on either form (other than the risk of fatality noted on the hospital consent form) or in Respondent's January 22 or February 7, 2001 forms. While the standard of care may not require the listing of all of the risks, complications or alternatives in these documents, the absence of such an enumeration of what specifically was discussed allows more weight to be given Steve F.s assertion that he was not informed of all of the risks, complications and alternatives of the procedures.

70(d). The evidence established Steve F. was not informed of all of the risks, complications and alternatives associated with a provocative lumbar discogram and endoscopic discectomy.

71(a). Complainant alleged in the Second Amended Accusation, paragraph 31, page 11, lines 1 through 3, that "Respondent did not advise Steve F. of the risks and benefits associated with a provocative lumbar discogram and endoscopic diskectomy. This discussion is not documented in the medical record."

71(b). Although Complainant did establish, by clear and convincing evidence, that Respondent did not advise Steve F. of all of the risks and benefits associated with a provocative lumbar discogram and endoscopic discectomy, Complainant did not establish that such a discussion "is not documented in the medical record." Such a discussion was documented, although it was not proven that it took place as described.

72. On February 8, 2001, Steve F. traveled from his home in Madera to Simi Valley to undergo the planned procedure at the Simi Health Center.

73. On that date, Steve F. also signed an informed consent on a Simi Health Center form, consenting to performance of the lumbar discectomy at the Simi Health Center. This form stated:

> I have been informed that there are certain risks in the operation(s) and complications may occur at surgery and in the post operative period. These complications may be serious or fatal. I have been fully informed of the nature of the surgery and the purpose for which it is performed. I have been informed of other alternative methods of treatment.

74. The Simi Health Center anesthesia record indicates that anesthesia began at 10:30 a.m. and ended at 2:40 p.m., and that the procedure began at 10:55 a.m. and ended at 2:10 p.m. Respondent's February 8, 2001 operative report indicated that Local/MAC anesthesia was used. The operative report contained a description of the operation, which included the following:

> [A]fter regular prep and drape and under .5% local Xylocaine anesthesia, provocative lumbar discogram of L2, L3 and L4 was performed with posterolateral approach with with 3 cc. Ominipaque dye injected under digital pressure with positive reproduction of preoperative pain and abnormal discogram of L2, L3 and L4 noted.

75(a). Looking at the February 8, 2001 report's indication of "positive reproduction of preoperative pain," Respondent testified that this indicates that the patient was able to talk to him and that, from the patient's oral responses, he was able to reproduce preoperative pain.

75(b). Steve F. testified that he did not have any conversation with anyone during the procedure. He noted that he may have said something to the anesthesiologist when she placed a needle in his arm, but that was the only conversation he had. He insisted that he did not answer any questions regarding the replication of his pain, or anything to that effect.[18]

75(c). Steve F. also maintained that, despite Respondent's assurances that the procedure would be performed under local anesthesia, this was not what occurred. According to Steve F., "they knocked me out at some point in time, which was not our agreement." Steve F.'s wife, Susan F. also testified that, the procedure took longer than anticipated and that when she asked Respondent about this after the procedure, he informed her that they had to use general anesthesia. However, the anesthesia record from Simi Health Center indicated only the use of MAC, without general anesthesia.

75(d). The clear and convincing evidence established that Respondent did not have intra-operative discussions with Steve F. during the provocative discogram. Respondent did not testify that he had an independent recollection of the intra-operative discussion with Steve F. Given his documentation of other conversations which did not necessarily take place as described (See Factual Findings 70 and 71), Respondent's insistence that an intra-operative conversation took place is given less weight than Steve F.'s independent recollection of no intra-operative conversations.

76. On February 8, 2001, Steve F. was discharged from Simi Health Center after 4:30 p.m. Steve F. walked out of the hospital and stayed overnight at one of the motels recommended by Respondent's office staff. Susan F. obtained the Vicodin that Respondent had prescribed for relief of post operative pain, and Steve F. began taking that medication.

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[18] There was no evidence that the MAC may have had any affect on the patient's ability to recall any intra-operative discussions.

77(a). A document entitled Same Day Discharge Instructions was contained in Steve F.'s medical records. That document included the following instruction:

> You should see Dr. ____tonight_____ on ___2-8-01___
> Alert your physician if you have:
> Persistent/abdominal bleeding — Continuous or severe pain
> Difficulty Breathing — Persistent nausea and/or vomiting
> A fever or chills — Difficulty urinating

77(b). Instead of specifying a doctor's name in the appropriate blank, the word "tonight" was inserted. No specific doctor was identified as the physician to see on February 8, 2001.

78(a). Steve F. and Susan F. testified that, when they left Simi Health Center, no post operative appointments had been set by Respondent's staff. Steve F. and Susan F. both testified that, on the night of February 8, 2001, Steve F. did not return to see Respondent or any of Respondent's colleagues.

78(b). Respondent asserted that, on February 9, 2001, Steve F. returned to Respondent's office, that Respondent examined him and that a post-operative x-ray was taken. During his testimony, Respondent pointed to a February 8, 2001 progress note and a February 8, 2001 x-ray as support for his assertion that Steve F. returned for a post operative examination that night. However, this assertion is not persuasive, for the following reasons:

(1). A February 8, 2001 progress note was contained in Steve. F's records and produced by Respondent to the Board. The note indicated that "post surgery," the patient was "doing well" with "no complaints," and that a neurological examination was conducted. The February 8, 2001 progress note was placed on the same page as, and just below, a February 2, 2001 pre-operative progress note. However, none of Respondent's other progress notes admitted into evidence combine more than one day's notes on a page. Instead, for all the other progress notes, the note for each date is on a separate piece of paper. Consequently, the February 8, 2001 entry appears to be a later-added note and is suspect. It cannot be relied upon to establish that a post surgery exam was conducted on Steve F. on the night of February 8, 2001, after he had been discharged from the hospital.

(2). Contained in Steve F.'s medical records is an x-ray report, dated February 8, 2001, entitled "Lumbar Spine, Two Views, Post Op." There is no indication of the time the x-rays were taken. Neither Steven F. nor his wife recalls any post-operative x-rays being taken after Steve F. left the hospital. Therefore, the x-ray report cannot be relied upon to establish that a post surgery examination was conducted on Steve F. on the night of February 8, 2001, after he had been discharged from the hospital.

79. On February 9, 2001, Steve F. and his wife returned home to Madera. He began to experience severe pain, and by February 11, 2001, he was in so much pain that he

could not get out of bed. Between February 11 and 19, 2001, Steve F. remained in bed with continually increasing pain and nausea.

80. On February 12, 2001, Steve F.'s wife called Respondent's office several times to find out what to do for Steve F.'s pain. Respondent prescribed Dexamethasone and Ranitidine, and Susan F. picked up the phoned-in prescriptions at the Longs Drugs near her home. The Longs Drugs records indicate that the prescribing physician was "J. Chiu."

81. On the morning of February 14, 2001, Respondent took a flight out of Los Angeles International Airport to attend neurosurgery seminars in Bombay, India and in Colorado. He returned to Los Angeles after 11:00 p.m. on February 19, 2001. The trip had been planned at least several weeks in advance, and a note at the bottom of Respondent's itinerary indicated that "1/25/01 purchased ticket."

82(a). Steve F. was not aware that Respondent was going out of town for medical seminars following his February 8, 2001 surgery, and was not told so.

82(b). Respondent testified that he did not recall discussing his anticipated absence with Steve. F., but that he was "sure" he had done so. Respondent did not explain how he was so "sure" he had done so, without any recollection of the discussion. Additionally, given that Respondent had told Steve F. before the surgery he would walk out of the hospital following the surgery (which he did) and that he could immediately return to leading his normal life, it seems unlikely that Respondent would have felt the need to inform Steve F. of his anticipated absence beginning seven days post-surgery. Consequently, Respondent's unfounded insistence that he had informed Steve F. of his anticipated absence is not persuasive.

83. Susan F., who was very worried about her husband's condition, called Respondent's office twice on February 15, 2001, and eleven times on February 19, 2001, to get help for her husband. She spoke to Respondent's staff member named Trish, who never told her that Respondent was out of town. Susan F. never spoke to Dr. Thomas Clifford during those phone calls.

84. On February 15, 2001, a prescription for Carisoprodol was phoned into the Longs Drugs near Steven F.'s home, and Susan F. picked up that prescription. On February 19, 2001, prescriptions for Cyclobenzaprine, Dexamethasone and Ranitidine were phoned into the Longs Drugs near Steven F.'s home. The Longs Drugs records indicate that the prescribing physician for the Carisoprodol, Cyclobenzaprine, Dexamethasone and Ranitidine was "J. Chiu."

85. On February 19, 2001, during one of Susan F.'s phone calls to Respondent's office, Trish told her the she needed to use "tough love" and that she needed to move Steve F. However, she could not do so, and therefore called an ambulance. On that date, Steve F. was taken by ambulance and admitted to St. Agnes Medical Center in Fresno, California,

with severe lower back pain. He also had a slight temperature elevation. He remained at St. Agnes for 21 days.

86(a). Respondent testified that Dr. Thomas Clifford, a board certified neurosurgeon, and an associate of his, would cover Respondent's patients when Respondent left town. Respondent insisted that, when he was out of town in February of 2001, Dr. Clifford was in charge of covering his patients, including Steven F. He asserted that the doctor left in charge is 100 percent responsible for the patients.

86(b). Respondent's assertion that Dr. Clifford was left in charge of Steven F.'s care from February 15 through February 19, 2001, was not convincing for the following reasons:

~~(1). The prescriptions for February 15 and 19, 2001 were issued with~~ Respondent listed as the prescribing physician, not Dr. Clifford. Respondent attempted to explain this documentation, stating that, although his staff asked Dr. Clifford for the prescription, they automatically used Respondent's name on the prescription because Respondent was the patient's physician. He noted that Dr. Clifford's name should have been on the prescription and that occurrence was an exception to what usually happens. However, Respondent's explanation is not credible, since the "exception" happened on two occasions. Additionally, if Dr. Clifford had been in charge of Steve F.'s care, and (by Respondent's account) 100 percent responsible for the patient during that time frame, it seems more likely that he would have issued the prescription under his own name. Notably, Dr. Clifford did not provide testimony to clarify this issue.

(2). Contained in Steve F.'s medical records was a progress note, dated February 20, 2001, signed by Dr. Thomas Clifford, indicating:

> Was notified [that Steve F.] was in [the] ER . . . at St. Agnes Med. Center . . . [with] low back pain & muscle spasm. Spoke [with] wife – he had been "unable to move, to get out of bed" for 5 days.

Dr. Clifford's February 20, 2001 progress note appears to indicate that Dr. Clifford was unaware of the patient's inability to get out of bed for five days until he was informed by Steve F.'s wife on February 20, 2001. This does not support Respondent's assertion that Dr. Clifford was in charge of his patient from February 14 through 19, 2001.

(3). During the numerous frantic phone calls made by Susan F. to Respondent's office between February 15 and February 19, 2001, Respondent's staff never informed Susan F. that Dr. Clifford was covering Respondent's patients.

(4). During the numerous phone calls made by Susan F. to Respondent's office between February 15 and February 19, 2001, Dr. Clifford never talked to Susan F.

(5). Respondent never told Steven F. that Dr. Clifford would be covering for him from February 15 through February 19, 2001.

(6). There was no evidence (testimonial or otherwise) that Dr. Clifford ever accepted responsibility to cover Respondent's patients between February 15 through February 19, 2001.

87. On February 21, 2001, Respondent wrote his first post operative follow up note in the Steve F. case, which summarized what had occurred after Steve F.'s surgery.

88. On March 1, 2001, a CT-guided needle biopsy of the patient's L-3 disc space was performed because of a concern of disc space infection. The culture was negative. On March 6, 2001, a biopsy of the L2-3 and L3-4 levels was taken, with negative results. Since there was a prospect of disc space infection, a course of antibiotics was started, after which there was improvement of the patient's symptoms. Steve F. was discharged from St. Agnes Medical Center on March 13, 2001, with a discharge diagosis which included "postoperative lumbar microdiskectomy with presumed infectious spondylodiscitis at L2-3 and possibly L3-4 levels." He was ordered to continue the course of antibiotics at home, which he did. He also began physical therapy on October 1, 2001.

89. On December 7, 2001, Steve F. was readmitted to St. Agnes Medical Center, after a December 5, 2001 MRI showed an abscess and infection at L2-3. Steve F. was discharged on December 13, 2001, and began another course of antibiotics.

The Experts

90(a). Complainant offered the testimony of Willim R. Taylor, M.D. to establish the standard of care. Dr. Taylor obtained his medical degree from University of California Los Angeles in 1987 and is licensed to practice medicine in California. Dr. Taylor completed his residency in neurological surgery at Albert Einstein College of Medicine in New York (1988-1993), and then completed a NY Spine Fellowship at Columbia University in New York (1993-1994). He has been a diplomate of the American Board of Neurological Surgery since 1996. He has held teaching positions at University of California San Diego, Division of Neurological Surgery, as an Assistant Clinical Professor (1994-2000), an Associate Clinical Professor (2000-2007) and a Clinical Professor, his current position. Dr. Taylor currently treats patients and specializes in spine surgery, with an interest in minimally invasive surgery. He is currently involved in six clinical trials focusing on various subjects, including minimally invasive surgery. He has had numerous peer-reviewed articles published pertaining to the field of neurology.

90(b). Respondent offered the testimony of Martin Krell, M.D. to establish the standard of care. Dr. Krell obtained his medical degree from University of Southern California in 1965. He has been licensed to practice medicine in California since 1966 and has been a diplomate of the American Board of Neurological Surgery since 1975. He completed a residency in general surgery at University of California Los Angeles, Wadsworth Veterans' Hospital (1966-1967) and completed a residency in neurosurgery at University of California Irvine, Long Beach Veterans Administration (1967-1972). He has

been a Clinical Assistant Professor of Neurosurgery at USC from 1985 through the present. He has also held several professional appointments, including Chief of Surgery (1984-1985) and Chief of Staff (1986-1987) at Daniel Freeman Marina Hospital, Chairman of the Peer Review Committee, Division of Neurosurgery at Cedars-Sinai Medical Center (1993-1996), and Chief of Neurosurgery (2001-2004) at Century City Hospital.

90(c). Both Dr. Taylor and Dr. Krell were equally qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

90 (d). Respondent also offered the testimony of Board-certified orthopedic surgeon Vert Mooney, M.D. to establish the standard of care. Although Dr. Mooney is certified in a different specialty, his testimony focused on the standard of care for spine surgeons, and demonstrated that there is "overlap" in the two specialties (orthopedic surgery and neurosurgery) for certain procedures on the spine. Dr. Mooney's testimony was considered to supplement Dr. Krell's testimony regarding the standard of practice in particular procedures. However, only Dr. Krell's testimony was relied upon to establish the standard of care for neurosurgeons and whether Respondent breached that standard of care.

Standard of Care Re: Treatment of Donna A.

91(a). Dr. Taylor opined that Respondent failed to address Donna A.'s peri-operative problems and complications. He noted that Respondent's only extreme deviations from the standard of care were his failure to treat the patient's hematoma and his failure to secure an airway.

91(b). Dr. Taylor testified that, if blood came out from the inserted surgical needle, and Respondent removed and reinserted the needle, the appropriate response within the standard of care would have been based on the amount of blood at the time. He first stated that it would be below the standard of care for a neurosurgeon to apply pressure for only 30 seconds after seeing the blood. However, he later stated that, if pressure is applied for 30 seconds and "everything is okay," then that is an adequate response. He also testified that applying pressure for five minutes would likely reach the standard of care, but the neurosurgeon would still need to monitor the patient for development of a hematoma. According to Dr. Taylor, if the patient became hoarse, agitated and restless, and Respondent asked Dr. Shahangian to address the hoarseness and agitation with dexamethasone because he believed the symptoms indicated an allergic reaction, Respondent's course of action would have been proper. If the patient continued with the outward signs of hoarseness and restlessness, and the anesthesiologist believed that a hematoma was developing and that a bulge was forming on the right side of the patient's neck at the needle's point of entry, Respondent would have to revisit decision of how to proceed. However, there is no specific time limit for making such a reassessment. According to Dr. Taylor, if the patient is able to talk and breathe, the timing of the reassessment would depend on how patient is doing.

91(c). Dr. Taylor further testified that, once a neurosurgeon discovers the existence of a hematoma in a patient, the situation becomes an "absolute medical emergency." The standard of care requires that an airway be established immediately by intubation or tracheostomy and, at the same time, the surgeon must evacuate the hematoma by incision in the neck.

91(d). Dr. Taylor asserted that the standard of care requires neurosurgeons to be able to establish a surgical airway by tracheostomy, and that this skill is still required for Board certification for neurosurgeons. He also asserted that it would be within the standard of care for neursurgeons to be able to perform a cricothyrotomy. Dr. Taylor noted that a surgical airway was necessary for Donna A.. He opined that Respondent's closing the patient after the attempted tracheostomy was not appropriate, since proper treatment of the hematoma required draining the hematoma with an incision in that area. He admitted that, if Respondent abandoned the tracheostomy because of a 100 percent reading on the pulse oxymeter, he "would have less concern about proceeding with a tracheostomy." However, he noted that the pulse oxymeter is only one of the factors to look at, and that the readings can drop quickly.

91(e). In rendering his opinion that Respondent failed to treat Donna A.'s hematoma, Dr. Taylor assumed that a hematoma formed as a result of Respondent's actions. Dr. Taylor assumed that Respondent inserted the trochar into Donna A.'s neck and saw blood; that 10 minutes later, Donna A. became hoarse, agitated and restless; and that, as stated in the autopsy report, an internal jugular vein tear was the likely cause of a hematoma. However, these assumptions were not borne out by the evidence. (See Factual Findings, above.) Additionally, Dr. Taylor admitted that, if it was established that a hematoma was not causing a problem for the patient, this would change the surgeon's need to address that problem.

91(f). On cross examination, Dr. Taylor agreed that the anesthesiologist is "in charge of the airway" and the surgeon is "in charge of the operation." Dr. Taylor admitted that, assuming that no hematoma existed; that the anesthesiologist decided to convert to general anesthesia, administered propofol and succynolcholine, and made multiple attempts to intubate using laryngoscopes with Miller and Macintosh blades; that the anesthesiologist was unable to see the epiglottis or vocal chords and was unable to place an endotracheal tube; that the anesthesiologist subsequently used an LMA, connected to the anesthesia machine, and manually tried to pump air in; that the anesthesiologist asked Respondent to perform a tracheosotomy leading to a tracheotomy to establish a surgical airway; and that Respondent made the incision, but was unable to complete the tracheostomy, Respondent did not commit a major deviation from the standard of care. Dr. Taylor also admitted that, assuming Respondent nicked the internal jugular vein and caused some bleeding from the low pressure vessel which did not form a discrete hematoma; that the tissues and muscles surrounding the internal jugular vein were intact except at the place of puncture; that there was no tracheomalacia, distortion or deviation of the trachea; that the patient was agitated, complaining and talking to a nurse; that Respondent requested additional conscious sedation, not general anesthesia; but that the anesthesiologist decided to convert to general anesthesia and went through the process stated above, Respondent committed no major deviation from

the standard of care. Dr. Taylor noted the fact that Respondent did not participate in the decision to convert to general anesthesia makes a difference in his analysis, because "you are changing over your roles and changing the course of procedure, since you are now talking about securing an airway." Dr. Taylor opined that, if the anesthesiologist converted to general anesthesia without instruction from Respondent, it made Respondent's "job more difficult," since he had to deal with a patient who had just been paralyzed, sedated and could not be intubated. Dr. Taylor stated that this was a "difficult position to put a surgeon in," and that he was unable to opine, within a reasonable degree of medical certainty, that Respondent engaged in a major deviation from the standard of care under those circumstances.

92(a). Dr. Krell testified that, assuming the anesthesiologist decides to convert to general anesthesia and administers propofol and succynolcholine; that the anesthesiologist cannot visualize the epiglottis and vocal chords and is unsuccessful in intubating the patient; that the patient is not breathing because she is paralyzed from succynolcholine; and that a neurosurgeon is asked to attempt tracheostomy leading to tracheotomy, it is not below the standard of care for the neurosurgeon to be unable to complete the tracheostomy. According to Dr. Krell, the neurosurgeon may not know how to perform a tracheostomy or may not have performed such a procedure for an extended amount of time. Dr. Krell also noted that the patient may have an anatomy which makes a tracheostomy difficult, such as a short neck or being overweight with fat on the neck and chest, which makes the approach to the trachea difficult.

92(b). Dr. Krell testified that the history and physical that Respondent performed on Donna A. on November 25, 2002, constituted a full neurological examination of the patient. The ensuing report set forth the patient's history of problems and treatment, a review of her symptoms, documentation of a physical examination which included a neurological examination to determine the patient's current manifestations, a review of radiological studies and recommendations which included a discussion of the risks and alternatives of the proposed procedures. Dr. Krell opined that the standard of care does not require the neurosurgeon to specifically state the levels of the cervical spine on which he is going to operate. According to Dr. Krell, a neurosurgeon could be looking at multiple levels in a procedure and may discover that a level not previously suspected is causing pain. In that instance, it is not feasible to wake the patient to obtain consent to operate on that additional level.

93. Dr. Mooney confirmed that Respondent's November 25, 2002 preoperative evaluation met the standard of care for spine surgeons. He noted that, in the recommendations section of the report, it is not necessary for a surgeon to lay out every risk and element that was discussed with the patient.

94. With regard to the Donna A. case, based on the facts established by the evidence and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent committed any deviations from the standard of care.

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Standard of Care Re: Treatment of John C.

95. Dr. Taylor testified that Respondent committed only minor deviations/ simple departures from the standard of care in his treatment of John C.

96. Dr. Taylor opined that, based on the operative report, there is no evidence of intra-operative discussions with the patient, nor any documentation of his level of consciousness. This was below the standard of care. Dr. Taylor found it significant that the operative report was almost identical to the operative report in Steve F.'s case, so that in both cases there were three levels of positive discography and then three levels of discectomy.[19]

97. Dr. Taylor opined that Respondent's record keeping fell below the standard of care because there was no evidence of documentation in the post-operative chart concerning the patient's post operative visit. This opinion was unchanged even after the progress notes from the patient's post-operative visits were forwarded to the Board and then to Dr. Taylor. As indicated above in Factual Finding 65, Complainant did not prove that "Respondent failed to document the patient's post operative visits on August 29, 2002 and September 17, 2002."

98(a). Dr. Taylor noted that John C. had a post operative complication of a recurrent disc herniation at the L4-5 level, along with right-side leg pain and weakness. According to Dr. Taylor, Respondent needed to continue to seek the cause of the new right-sided neurological finding after surgery. Respondent did not identify any right foot drop in his post operative notes. However, relying on the records of John C.'s subsequent treating physicians, Dr. Taylor noted that, on October 1, 2002, Dr. Fogal identified a right foot drop and right side weakness. Additionally, an MRI conducted on October 3, 2002, revealed a herniated disc at L4-5 toward the right side and spondylolysthesis. According to Dr. Taylor, the herniation could cause right side radicular leg pain.

98(b). Dr. Taylor noted the administration of SI joint trigger point injections and prescription of Neurontin is an adequate response to post operative pain. However, this prescription must be coupled with an investigation into why a patient has new post operative symptoms. Dr. Taylor opined that, in John C.'s case, SI joint trigger point injections were not an adequate response. Given the preoperative spondylolysthesis and normal neurological examination, a post –operative foot drop and severe right-sided radicular pain should have been evaluated with an MRI scan, unless a clear indication of its cause was found. While an

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[19] This duplication in language is not sufficient to contradict Respondent's assertion that he had intra-operative discussions with the patient. Respondent may have failed to document specifically what the patient said when the discography produced "positive reproduction of pain." However, the Second Amended Accusations alleges only that "Respondent failed to have any discussions with John C. during the August 16, 2002 procedures," not that he failed to document the specifics of those discussions. As set forth in Factual Finding 57, the evidence established that Respondent had intra-operative discussions with the patient and that the patient responded verbally regarding the pain he felt.

EMG and CT scan are typically ordered, these are not as helpful as an MRI. In John C.'s case, the EMG revealed radiculopathy at L-5, and the CT scan did not reveal the cause of the new symptoms. An MRI was needed to evaluate for herniated discs. Dr. Taylor opined that Respondent's failure to seek a reason for the new neurological deficit after an EMG revealed L-5 radiculopathy fell below the standard of care for neurologists.

99. Dr. Krell opined that Respondent's August 15, 2002 history and physical report met the standard of care for board certified neurologists. Although the report noted a discussion of risks without listing all of them specifically, if Respondent discussed them all as he testified, the report meets the standard of care.

100. Dr. Krell testified that, in the operative report, the phrase "positive reproduction of preoperative pain and abnormal discogram of L3, L4 and L5 noted," implied that, in order to obtain that information, the patient was sufficiently conscious to be able to relate his symptoms to Respondent during the discogram. The phrase also implied that some communication took place between the patient and Respondent. Consequently, Dr. Krell opined that the operative report met the standard of care for neurologists.

101(a). Dr. Krell noted that post-surgically, John C. was complaining of pain in a non-surgery area. However, he noted that the SLR test was "slightly abnormal, almost normal." According to Dr. Krell, the September 17, 2002 progress note does not document any significant injury or problem. He opined that Respondent's examination represented a reasonable examination of the patient's complaint. He further opined that Respondent's ordering an EMG was appropriate since the patient was complaining of weakness in his foot, "a dropped foot," and an EMG could determine if a nerve was injured. However, Dr. Krell insisted that, at the time, the patient was not suffering from a "full-on foot drop." He noted that it is often "hard to interpret" based on cooperation of the patient or "breakaway weakness from pain." He also noted that Dr. Kissel's later examination did not indicate a "clear cut foot drop," but only mild weakness.

101(b). Dr. Krell opined, assuming that the patient was about 80 years old and intolerant and that, on September 17, 2002, Respondent chose to order a CT scan over an MRI because the CT scan took only a couple of minutes and the MRI took 30 to 40 minutes, requiring patience and confinement, Respondent's ordering of the CT scan was within the standard of care.[20] Dr. Krell stated that an MRI "picks up water," so if a physician orders an MRI within a few months after surgery, he/she may see water signals intermingled with inflammation, and it is very hard to interpret and may give a false positive. Therefore, a CT scan within the first three months of an operation is within the standard of care, and is in fact the standard of care. Dr. Krell opined that Respondent did not fall below the standard of care in his post operative care of John C.

[20] As indicated in Factual Finding 64, the patient's intolerance was belied by the fact that he underwent MRIs prior and subsequent to September 17, 2002.

102. Dr. Mooney testified that the Neurontin and SI joint injections adequately addressed the patient's complaints until Respondent obtained the information from the CT scan. Dr. Mooney stated that, after Respondent had the appropriate information from the CT scan, he should have started to consider other mechanics to address the post operative complaints. However, Dr. Mooney opined that Respondent should not order an MRI unless it is necessary (i.e. the CT scan does not tell him enough). He noted that a CT scan is an appropriate method of assessing reherniation of discs, just like an MRI.

103. Based on Factual Findings 49, 51 and 56, and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent deviated from the standard of care in his pre-operative evaluation discussing the risks and benefits of the procedures performed.

104(a). Based on Factual Findings 49, 51, 52, 54, 55 and 57, and the collective opinions of Drs. Taylor and Krell, it was not established that Respondent deviated from the standard of care during the August 16, 2002 procedure because it was not proven that he "failed to have any [intra-operative] discussions with John C."

104(b). With regard to Respondent's failure to document John C.'s level of consciousness in the operative report, the opinions of Dr. Taylor, set forth at Factual Finding 96, were more persuasive than those of Dr. Krell, and are adopted as facts herein.

105. Based on Factual Findings 59, 61 and 65, and the collective opinions of Drs. Taylor, Krell and Mooney, it was not established that Respondent departed from the standard of care in his documentation of post operative visits, since it was not proven that Respondent "failed to document [John C.'s] post operative visits on August 29, 2002, and September 17, 2002."

106. With regard to John C.'s post operative complaints, the testimony of Dr. Taylor was more persuasive than that of Drs. Krell and Mooney. Therefore, the opinions of Dr. Taylor, set forth in Factual Finding 98, are adopted as facts herein. As indicated by Dr. Krell's testimony, the patient was complaining of weakness in his right foot, although Respondent did not identify this as a problem or interpret it as a "dropped foot." Given the weakness and radiculopathy, the standard of care required Respondent to seek to determine the reason for any new neurological deficit by way of an MRI.

Standard of Care Re: Treatment of Steve F.

107(a). Dr. Taylor testified that, following lumbar discograms and endoscopic discectomies, due to the insertion of instruments into the disc space, the patient can develop the post operative complication of discitis, an inflammation of the disc space, which often involves a bacterial infection in that location. The patient suffering from discitis typically has recurrence of radiculopathy and debilitating, severe lower back pain. Discitis takes a long time to treat, and the standard of care for the treatment of discitis is the use of

antibiotics. Usually a biopsy is conducted to tailor the antibiotics, but often the biopsy is negative because no bacteria can be cultured out of the disc area.

107(b). Dr. Taylor opined that Respondent's post operative care of Steve F. fell below the standard of care for post operative treatment. Based on the patient's lower back pain, severe recurrence of symptoms, blood test results and low grade fever with an MRI consistent with discitis at L2-3, Dr. Taylor opined that Respondent failed to recognize that Steve F. had developed the post operative complication of infection. None of the medications prescribed by Respondent addressed the patient's infection. Instead, the medications prescribed were an anti-inflammatory medication (e.g. Dexamethasone), a medication for stomach upset (e.g. Ranitidine) and muscle relaxants, prescribed for acute radiculopathy or muscle pain after surgery. Although discitis symptoms must be dealt with quickly, Dr. Taylor noted that the patient did not receive appropriate treatment for his infection until he went to St. Agnes Medical Center. Therefore, Respondent did not timely respond to Steve F.'s infection. Dr. Taylor acknowledged that, although a neurosurgeon need not assume immediately that an infection is present, he/she must consider the severity of the illness. Infectious discitis is debilitating and very severe, and in this case, the patient was experiencing debilitating pain, along with fever and testing that indicated infection. Taylor found it significant that the patient called Respondent's office so many times. According to Dr. Taylor, Respondent's failure to respond to the patient's numerous calls falls below the standard of care for treatment in a post-operative setting. Dr. Taylor noted that, if Respondent had responded to the patient's calls, it should have been easy for Respondent to identify that the patient was suffering from discitis and would have been able to care for him. Dr. Taylor opined that Respondent's deviation from the standard of care in Steve F.'s post operative treatment was a major departure from the standard of care and equivalent to gross negligence.

107(c). Dr. Taylor further opined that it is a deviation from the standard of care if a patient is left with no competent physician in charge of taking care of this problem. He emphasized that a family doctor or primary care physician is not capable of addressing the post-operative complications of infection, and that it is incumbent on the neurosurgeon to follow up or to arrange follow up by a competent neurosurgeon, if he/she is unable to personally follow up with the patient. Dr. Taylor admitted that, if Respondent had left a Board-certified neurosurgeon, with whom Respondent had a history in practice, in charge of his patients when he left town, that would make a significant difference in his opinion. However, as set forth in Factual Finding 86, it was not established that Dr. Clifford had been responsible for Respondent's patients, including Steven F., when Respondent was out of town from February 15 through 19, 2001.

108(a). With regard to Respondent's preoperative evaluation report for Steve F., Dr. Taylor testified that, assuming Respondent discussed with Steve F. that infection could be a complication of his surgery, the document was sufficient to convey that the patient had been so advised. However, as set forth in Factual Findings 70 and 71, despite Respondent's documentation of such a discussion, Steve F. was not informed that infection was one of the risks or complications associated with a provocative lumbar discogram and endoscopic

discectomy. Dr. Taylor did not testify that the failure to have this discussion, in itself, was a violation of the standard of care. However, it can be assumed that, if documentation of the discussion is required by the standard of care, then the conversation itself must be required as well. Additionally, given that Dr. Taylor found the document sufficient only if Respondent actually discussed the complications of surgery, the actual conversation appears to be the key component of Dr. Taylor's analysis, with the documentation used only to confirm compliance with the standard of care.

108(b). Moreoever, although Dr. Taylor did not so testify specifically, the documentation of a conversation that did not take place constitutes a failure to keep accurate records. This lack of accuracy is easily apparent to a lay person and does not need to be established by expert opinion.

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109. Dr. Taylor opined that, based on the operative report, there is no evidence of intra-operative discussions with the patient, nor any documentation of his level of consciousness. As with John C., this was below the standard of care. Steve F.'s operative report and records revealed that a provocative discogram was done, concurrent with an EMG. The neurosurgeon needs to tailor post-discogram treatment to what the patient tells the surgeon at the time of the discogram. Based on the operative report, Respondent apparently proceeded to a three-level discectomy based solely on an intra-operative, three-level provocative discogram, without reliance on patient input. There was no indication as to whether Steve F.'s leg pain had been caused by L2-3, L3-4 or L4-5. Dr. Taylor opined that there was no indication in the operative report that Respondent obtained any patient response or that the provocative discogram had any effect on which procedures were subsequently performed.

110. When asked if Respondent should have documented all of the post operative phone calls made to his office, Dr. Taylor testified that "it is a matter of degree." If a patient makes one or two calls and is unable to get a hold of someone, those calls need not be documented. However, "a continual inability needs to be documented." This testimony was insufficient to establish that the standard of care required that Respondent document all post-operative checks and that Respondent "failed to document the patient's post-operative checks and numerous telephone calls, and thereby departed from the standard of care."

111. Dr. Krell testified that, when Steve F. called Respondent's office complaining of pain in the disc area operated on, two days after his percutaneous lumbar discectomy, and Respondent prescribed dexamethasone, Vicodin and Zantac, this met the standard of care for addressing initial complaints of pain following discectomy. Dr. Krell acknowledged that the medications prescribed for Steve F. did not address infection. However, he pointed out that a neurosurgeon with a patient complaining of post-operative pain need not immediately consider infection within the first few days post-surgery. He testified that he did not think that, at that time, Steve F. had discitis, but was merely complaining of pain. Nevertheless, Dr. Krell admitted that, it is reasonable that, with increasing pain, infection should be considered.

112. Dr. Krell testified that, assuming that a patient has a primary care physician and that there was some contact between that physician and the patient on an ongoing basis, it is reasonable to expect the neurosurgeon's out-of-town patient to see his own primary care physician during the post operative period.

113. Dr. Krell testified that, assuming Respondent left the country and arranged for Dr. Clifford, a board-certified neurosurgeon, to provide coverage for his patients, it would have been Dr. Clifford's responsibility to cover the patients. Dr. Krell also testified that, assuming Steve and Susan F. made numerous phone calls while Dr. Clifford was covering Respondent's patients, it would have been Dr. Clifford's responsibility to answer those calls. According to Dr. Krell, if the neurosurgeon has a physician's assistant cover his patients, then the patients would remain the responsibility of the neurosurgeon. However, if the neurosurgeon's colleague with the same qualifications covered his patients, then the patients are the colleague's responsibility. However, as set forth in Factual Finding 86, it was not established that Dr. Clifford was covering Respondent's patients, including Steven F., when Respondent was out of town from February 15 through 19, 2001.

114. Dr. Krell testified that Respondent's pre-operative evaluation of Steve F. was adequate, and that Respondent met the standard of care regarding discussion with the patient of the risks and benefits of the proposed procedures. However, Dr. Krell's opinion was based on the assumption that Respondent actually had a discussion with the patient regarding the risks of the proposed procedures. This assumption was not borne out by the evidence. As set forth in Factual Findings 70 and 71, despite Respondent's documentation of such a discussion, Steve F. was not informed of all of the risks, complications and alternatives associated with a provocative lumbar discogram and endoscopic discectomy.

115. Dr. Krell also opined that the history and physical report met the standard of care for neursurgeons in Southern California in 2001. However, as addressed in Factual Finding 108, the documentation of a conversation that did not take place does not meet the standard of care.

116. Dr. Krell testified that the operative report met the standard of care regarding the documentation of the patient's level of consciousness. As a board-certified neurosurgeon reading the operative report, Dr. Krell could ascertain the level of consciousness of Steve. F. during the provocative discogram because the report indicated that the patient was able to respond to the injection of the dye into the discs. Dr. Krell stated that he could tell from the report that the patient could appreciate pain because the patient could express the sensation of "positive reproduction of preoperative pain." Dr. Krell testified that the documentation of "positive reproduction of preoperative pain" is adequate documentation of discussions with the patient regarding the goal of the provocative discogram.

117. Except for the testimony noted in Factual Finding 110, the testimony of Dr. Taylor was more persuasive than that of Dr. Krell. Therefore, the opinions of Dr. Taylor, set forth in Factual Findings 107 through 109, are adopted as facts herein.

Alleged Bases for Discipline

118. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 13 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by a failure to "perform and document a preoperative assessment of Donna A.,"

119. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 14 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by a failure to "address peri-operative problem and complications" or by a "decision to allow the induction of general anesthesia in response to Donna A.'s coughing and becoming hoarse, agitated and restless and her developing a hematoma."

120. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 15 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by "inducing general anesthesia on Donna A., rather than stopping the diskogram procedure when she began to suffer complications."

121. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 16 and 17, because it was not established that Respondent committed gross negligence in his care and treatment of Donna A. by failing to place "a large bore needle into the [patient's] trachea and/or perform an exploration of the anterior cervical triangle to evacuate the blood clot prior to performing the tracheotomy;" by failing to "capably perform the operative procedures that can arise with the risks associated with a cervical discogram;" or by failing "to establish a surgical airway for Donna A."

122. Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 13, 14, 15, 16, and 18, because it was not established that Respondent committed repeated acts of negligence in his care and treatment of Donna A.

123(a). Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 26 and 28, that Respondent committed repeated acts of negligence in his care and treatment of John C. by his failure to document John C.'s level of consciousness and his failure "to perform an MRI on John C. to assess his complaints of severe right-sided radicular pain and right footdrop."

123(b). Complainant did not establish, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 25 and 27.

124. Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 39, that Respondent committed gross negligence in his care and treatment of Steve F. by failure "to personally follow-up with

Steve F. regarding his post-operative status," by failure to "refer Steve F. to a physician in his area to assess his post-operative status during the period of February 12 to 19, 2001," by failure to "identify that Steve F. may have been suffering from an infection, despite his thirteen [plus] telephone calls from February 12, 2001 to February 19, 2001 to his office complaining of lower back pain."

125(a). Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraphs 41 and 42, that Respondent committed repeated acts of negligence in his care and treatment of Steve F. by failing to "fully perform . . . a pre-operative evaluation discussing the risks and benefits of proposed procedures with the patient," and by failing to document intra-operative discussions with the patient."

125(b). Complainant did not prove, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 43, because it was not established that Respondent departed from the standard of care by failing to document the patient's post-operative checks and phone calls.

126. Complainant established, by clear and convincing evidence, the allegations in the Second Amended Accusation, paragraph 44, that Respondent failed to maintain adequate and accurate records relating to the provision of services to John C. (failure to document level of consciousness) and to Steve F. (failure to document intra-operative discussion and level of consciousness; and documentation of a conversation that did not occur).

Prior Discipline

127. In a Decision effective August 16, 2002, the Board issued a public letter of reprimand to Respondent.[21]

LEGAL CONCLUSIONS

First Cause for Discipline – Gross Negligence / Patient Donna A.

1. Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish that Respondent was grossly negligent in his care and treatment of patient Donna A., as set forth in Factual Findings 3 through 48, 91 through 94, 118, 119, 120 and 121.

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[21] Although the Second Amended Accusation alleged the bases for the issuance of the public letter of reprimand, these bases were not established by the evidence.

Second Cause for Discipline – Repeated Negligent Acts / Patient Donna A.

2. Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish that Respondent committed repeated acts of negligence in his care and treatment of patient Donna A., as set forth in Factual Findings 3 through 48, 91 through 94, 118, 119, 120, 121 and 122.

Third Cause for Discipline – Repeated Negligent Acts / Patient John C.

3(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds that Respondent committed repeated acts of negligence in his care and treatment of patient John C. (failure to document level of consciousness and failure to perform MRI) as set forth in Factual Findings 49 through 65, 95 through 106, and 123.

3(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds of repeated acts of negligence for failure to perform and document a preoperative evaluation and for failure to document post operative visits, in that Complainant failed to establish that Respondent committed these repeated acts of negligence in his care and treatment of patient John C., as set forth in Factual Findings 49 through 65, 95 through 106, and 123.

Fourth Cause for Discipline – Gross Negligence / Patient Steve F.

4. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Respondent was grossly negligent in his care and treatment of patient Steve F., as set forth in Factual Findings 66 through 89, 107 through 109, 117 and 124.

Fifth Cause for Discipline – Repeated Negligence Acts / Patient Steve F.

5(a). Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds that Respondent committed repeated acts of negligence in his care and treatment of patient Steve F. (failure to fully perform preoperative evaluation and failure to document level of consciousness and intra-operative discussions with patient), as set forth in Factual Findings 66 through 89, 107 through 109, 117 and 125.

5(b). Cause does not exist to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), on the grounds of repeated acts of negligence for failure to document post operative checks and phone calls, in that Complainant failed to establish that Respondent committed

this act of negligence in his care and treatment of patient John C., as set forth in Factual Findings 66 through 89, 110, 117, and 125.

Sixth Cause for Discipline – Failure to Maintain Adequate and Accurate Records

6. Cause exists to revoke or suspend Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, on the grounds that Respondent failed to maintain adequate records relating to patients John C. (failure to document level of consciousness) and Steve F. (failure to document intra-operative discussion and level of consciousness; and documentation of a conversation that did not occur), as set forth in Factual Findings 45 through 89, 95 through 106 through 109, 117, and 126.

Analysis re: Level of Discipline

7(a). Complainant established that Respondent committed gross negligence with one patient, repeated negligent acts with two patients and failed to maintain adequate and accurate records for two patients. The gross negligence was based on Respondent's absence rather than a lack of skill, and the repeated acts of simple negligence were based on failure to conduct an informed consent discussion, failure to perform an MRI and various documentation violations. The remaining question is the nature of the discipline to be imposed against Respondent's certificate.

7(b). Business and Professions Code section 2229, provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
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> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, [or] the division, . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . .

7(c). Business and Professions Code section 2227, subdivision (a), provides:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:
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> (1) Have his or her license revoked upon order of the division.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

(4) Be publicly reprimanded by the division.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

7(d). In determining the level of discipline, it is noted that Respondent has been disciplined previously, although (according to the Accusation) the prior discipline was not based on grounds similar to the current violations. While Respondent did not admit any violations at the hearing, this does not necessarily presage an unwillingness to undertake any rehabilitation ordered by Board. In light of the nature of his violations, a properly-conditioned probationary period will protect the public without imposing overly harsh and punitive discipline on Respondent.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Physician's and Surgeon's Certificate No C31784, issued to Respondent John C. Chiu, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for five years upon the following terms and conditions.

1. Notification

Prior to engaging in the practice of medicine, Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

6. Interview with the Division or Its Designee

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

7. Residing or Practicing Out-of-State

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the

practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws and Probation Unit Compliance.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

8. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and, for any reason, Respondent stops practicing medicine in California, Respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

9. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Division, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

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10. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Division reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Division or its designee, and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action.

If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

11. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

12. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall annually provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

13. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in medical record keeping, at Respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

14. Solo Practice

Respondent is prohibited from engaging in the solo practice of medicine.

15. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, Respondent's certificate shall be fully restored.

DATED: November 26, 2007

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings